State of Virginia STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER. A. BUILDING. \_\_\_ B WING VA0043 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH **GREENBRIER REGIONAL MEDICAL CENTER** CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID O (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 000 F 000 Initial Comments 000 An unannounced biennial State Licensure Inspection was conducted 04/10/19 through This plan of correction is 04/12/19 and 4/15/19 through 4/16/19. The facility respectfully Submitted in was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing response to deficiencies Facilities. 4 complaints were investigated during cited on 4/10/19 to 4/16/19. the survey. This plan of correction The census in this 120 licensed bed facility was constitutes a written 103 at the time of the survey. The survey sample allegation of substantial consisted of 36 current Resident reviews and 8 closed record reviews. compliance with the Federal Medicare and Medicaid F 001 Non Compliance F 001 requirements. The Submission of this plan of The facility was out of compliance with the following state licensure requirements: correction does not constitute an agreement that This RULE: is not met as evidenced by: 12 VAC 5-371-150 (D). Resident Rights. Cross the deficiencies exists, nor is Reference to F-572. it an admission that they existed. It is an expression of 12 VAC 5-371-150 (B)(1) Cross Reference To F-622, F-623, F-625. the Facilities desire to fully comply with the Medicare 12 VAC 5-371-250 B, C, D. Resident and Medicaid requirements. Assessment, Cross Reference to F640, F641. 12 VAC 5-371-220 C.1. Nursing Services. Cross Reference to F-684, F-686 12 VAC 5-371-220 D Nursing Services Cross Reference to F-687 RECEIVED 12 VAC 5-371-200 (A). Nursing/Director of MAY 2 8 2019 Nursing. Cross Reference to F-727. VDH/OLG 12 VAC 5-371-310 B. Diagnostic Services, Cross Reference to F770.

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

STATE FORM

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PRINTED: 05/23/2019 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER. COMPLETED A BUILDING \_\_\_\_\_ C B WING\_ VA0043 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY STATE. ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH **GREENBRIER REGIONAL MEDICAL CENTER** CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 001 Continued From page 1 F 001 12-VAC 5-371-300 A. cross referenced at F-tag 12 VAC 5-371-220 C. Nursing Service. Cross Reference to F810.

12 VAC 5-371-380. Laundry Services. Cross Reference to F-880.

12VAC5-371-180 Infection Control cross

referenced to F-880.

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		AND HUMAN SERVICES  & MEDICAID SERVICES				FORM APPROVE
STATEMEN	T OF DEFICIENCIES		T .	·	OM	B NO, 0938-039
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	TIPLE CONSTRUCTION  NG		X3) DATE SURVEY COMPLETED
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NAME OF	PROVIDER OR SUPPLIER		T	STREET ADDRESS, CITY, STAT	E 718 000E	04/16/2019
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E 000	Initial Comments		E 00	00		
	An unannounced E survey was conduct and 4/15/19-4/16/19	mergency Preparedness ed 04/10/19 through 04/12/19 ).			,	
E 004 SS=C	CFR Part 483.73, R Care Facilities. No complaints were inve	uired for compliance with 42 equirement for Long-Term emergency preparedness estigated during the survey. eview and Update Annually	E 00	4		
	Federal, State and ke preparedness required develop establish an	ements. The [facility] must d maintain a comprehensive lness program that meets the				
	with all applicable Fe emergency prepared [hospital or CAH] mu comprehensive emei	ospital or CAH] must comply deral, State, and local ness requirements. The st develop and maintain a gency preparedness he requirements of this				
1 ( 2 t	include, but not be lin elements:] (a) Emergency Plan. and maintain an eme	aredness program must nited to, the following The [facility] must develop rgency preparedness plan d], and updated at least			RECE	
}	rlan. The ESRD facili	•			VDH/	
JURATORY E	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE		(X6) DATE

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

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		TE SURVEY MPLETED
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GHEENE	BRIER REGIONAL ME	DICAL GENTER		ŧ .	CHESAPEAKE, VA 23323		
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	maintain an emerge must be [evaluated] annually. This REQUIREMEN by: Based on record refacility staff failed to facility's Emergency risk assessment.  The findings include During an interview the Administrator, as ister facility and the asked for the Emergency prepared Administrator stated facility for five days padministrator from the wast here to provide Administrator." Whe Emergency Prepare provided with a plan provided document of facility would operate and there were no core-establish essential emergency. The adhad not developed a plan that identified he the needs of the patioperation.  The facility staff faile identified needs of the pationers.	concy preparedness plan that and updated at least.  IT is not met as evidenced view, and staff interview, the have documentation of the Preparedness Plan identified of the Preparedness Program of the provide a comprehensive of the survey. The preparedness program of the Initial of the provide and the provided how the ended the provided how the ender potential interruptions contracts or arrangement to all services during an ministrator stated the facility emergency preparedness ow the facility would address ents and continuity of the facility and a	EO	)04	E 004 Develop the EP plan reviand update annually. The Facil Administrator will develop the plan for E 004. On how we worespond to an emergency and will put the contracts in place the assist us in doing this during a disaster. He will in-service all son it and will review it annually will take it to the QAPI committed meeting for review and approvement of the This will be a permanent fix to the citation.  RECE MAY 2	eity EEP uld we o staff . He tee al. this	)
	operation during an a	zotuai emergency.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '			(X3) DAT	TE SURVEY MPLETED
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\$S=C	EP Program Patient CFR(s): 483.73(a)(3) [(a) Emergency Plat and maintain an em that must be review annually. The plan of the program of the program of the Administrator, he documentation of the population at risk durated authority during an emergency.	n. The [facility] must develop ergency preparedness plan ed, and updated at least nust do the following:]  client population, including, ersons at-risk; the type of has the ability to provide in continuity of operations, s of authority and succession risk" does not apply to: ASC, A, CORF, CMCH, RHC, illities.]  T is not met as evidenced view, and staff interview, the have documentation of the equilation at risk during an energency and the facility's identified ring an emergency and the facility had not essment of it's resident ring an emergency; nor did mentation of delegation of	EC	007	E 007 The Facility Administrator develop documentation for the Facilities that will identify our apopulation during an emergence And the delegation of authority during an emergency / Disaster the Administrator is not present the building.  The Administrator will in-service staff on these items and will also present them at our next Month QAPI committee meeting for revand approval.  This will be a permanent fix to the citation.	eat-risk cy.  / c. If et in e all o hly view	5/31/19

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  ING	(X3) DATE SURVEY COMPLETED	•
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	the facility's identified documentation of documentation	d population at risk and elegation of authority during	E 0			
	[(a) Emergency Plar and maintain an em that must be review annually. The plan not seem that must be review annually. The plan not seem that must be review annually. The plan not seem to maintain an integration of the such officials and, we participation in collal planning efforts.  * [For ESRD facilities include a process for collaboration with loce and the seem to maintain an integration of the contact such officials participation in collat planning efforts. The the local emergency least annually to conform the dialysis facility emergency. This REQUIREMENT by:	n. The [facility] must develop ergency preparedness plan ed, and updated at least nust do the following:]  s for cooperation and cal, tribal, regional, State, and preparedness officials' efforts rated response during a cy situation, including e facility's efforts to contact hen applicable, of its porative and cooperative		E 009 The Facility Administrat develop and maintain an EPP includes a process for coopera and collaborating with local, to regional, and State and Federa emergency preparedness office. The Administrator will do an inservice for all staff and also takinformation to our QAPI commeeting. This will be a perman fix for this citation.	that eting ribal, el ials. el	P
OLA CIAC DED	7(02-99) Provinus Versions (	healata E ID-Conord				

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

Event ID: EQPC11

Facility ID: VA0043

If continuation sheet Prep of 147

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#### PRINTED: 05/23/2019 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

B. WING

495330

NAME OF PROVIDER OR SUPPLIER

**GREENBRIER REGIONAL MEDICAL CENTER** 

STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH

04/16/2019

CHESAPEAKE, VA 23323				HESAPEAKE, VA 23323	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 013 SS=C	Continued From page 4 facility staff failed to develop and maintain an emergency preparedness plan that include a process for cooperating and collaborating with local, tribal, regional, State and Federal emergency preparedness officials.  The findings included:  During an interview and review on 4/11/19 at 3:20 P.M. of the emergency preparedness plan with the Administrator he was asked for documentation of how the facility would maintain contact and cooperate with the local, tribal, regional, state and federal emergency preparedness officials. The administrator stated, the emergency preparedness plan did not have documentation of how to contact these officials.  The facility staff failed to develop and maintain an emergency preparedness plan that included a process for cooperating and contacting the local, tribal, regional, State, and Federal emergency preparedness officials.  Development of EP Policies and Procedures CFR(s): 483.73(b)  (b) Policies and procedures. [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.  *Additional Requirements for PACE and ESRD Facilities:	EO	13		
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# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		TE SURVEY MPLETED
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	procedures. The PA develop and implem policies and proced plan set forth in para assessment at para and the communicathis section. The po address manageme emergencies, include equipment, power, cemergencies; and not threaten the health of staff, or the public. The must be reviewed at implement emergency procedures, based of forth in paragraph (a assessment at paragraph	.84(b):] Policies and CE organization must hent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of licies and procedures must ent of medical and nonmedical ling, but not limited to: Fire; or water failure; care-related atural disasters likely to or safety of the participants, The policies and procedures and updated at least annually.  s at §494.62(b):] Policies and lysis facility must develop and cy preparedness policies and on the emergency plan set (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of icies and procedures must be end at least annually. These (a), but are not limited to, fire, failures, care-related supply interruption, and ely to occur in the facility's  T is not met as evidenced wiew and staff interview the develop and implement	E	013	E 013 the Facility Administrator cannot go back and meet the regulation of our plan meeting to November 2017 plan. What the Administrator will do is to devel an EPP plan that meets the requirements now. We will inservice all staff on that plan and take it to our QAPI meeting for approval. We will develop policiand procedures annually and ba on the facilities risk assessment communication plan.  This will be a permanent fix for to citation.	the lop I will cies ased and	5/31/19

#### PRINTED: 05/23/2019 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 495330 B. WING \_\_\_ 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH **GREENBRIER REGIONAL MEDICAL CENTER**

E 013  Continued From page 6 The findings included;  During an interview on 4/11/19 at 3:35 P.M. with the administrator he stated, the facility had not conducted an update to the emergency preparedness plan due to the facility initial emergency preparedness plan was not implement until 4/25/18. A review of the documents presented included information from a different facility as well as information that described the current building as being a two story dwelling. The Administrator was reminded that the initial emergency preparedness plan process went into effect as of November 2017.  The facility staff failed to develop and update policies and procedures annually and based on the facility's risk assessment and communication plan.  E 015  Subsistence Needs for Staff and Patients SS=C CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [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) 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:  (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:	GREEN	SHER REGIONAL MEDICAL CENTER	1	CHESAPEAKE, VA 23323		
The findings included;  During an interview on 4/11/19 at 3:35 P.M. with the administrator he stated, the facility had not conducted an update to the emergency preparedness plan due to the facility's initial emergency preparedness plan was not implement until 4/25/18. A review of the documents presented included information from a different facility as well as information that described the current building as being a two story dwelling. The Administrator was reminded that the initial emergency preparedness plan process went into effect as of November 2017.  The facility staff failed to develop and update policies and procedures annually and based on the facility's risk assessment and communication plan.  E 015  Subsistence Needs for Staff and Patients  CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) 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:  (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:	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFI)	IX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DATE		
the administrator he stated, the facility had not conducted an update to the emergency preparedness plan due to the facility's initial emergency preparedness plan was not implement until 4/25/18. A review of the documents presented included information from a different facility as well as information that described the current building as being a two story dwelling. The Administrator was reminded that the initial emergency preparedness plan process went into effect as of November 2017.  The facility staff failed to develop and update policies and procedures annually and based on the facility's risk assessment and communication plan.  E 015  Subsistence Needs for Staff and Patients  CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [Facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) 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:  (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:	E 013	· -	ΕO	013		
(i) Food, water, medical and pharmaceutical supplies	SS=C	the administrator he stated, the facility had not conducted an update to the emergency preparedness plan due to the facility's initial emergency preparedness plan was not implement until 4/25/18. A review of the documents presented included information from a different facility as well as information that described the current building as being a two story dwelling. The Administrator was reminded that the initial emergency preparedness plan process went into effect as of November 2017.  The facility staff failed to develop and update policies and procedures annually and based on the facility's risk assessment and communication plan.  Subsistence Needs for Staff and Patients CFR(s): 483.73(b)(1)  [(b) Policies and procedures. [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:  (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	E 01	915		

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7447) 999	(ii) Alternate source following:  (A) Temperature: safety and for the sprovisions.  (B) Emergency lie (C) Fire detection systems.  (D) Sewage and  *[For Inpatient Hosp Policies and proced (6) The following and hospice-operated in The policies and profollowing:  (iii) The provision of hospice employees evacuate or shelter limited to the following:  (A) Food, water, r supplies.  (B) Alternate sour following:  (1) Temperatur and safety and for the following:  (2) Emergency (3) Fire detection systems.  (C) Sewage and water this REQUIREMEN by: Based on record reversed in the following:	s of energy to maintain the sto protect patient health and afe and sanitary storage of ghting.  In, extinguishing, and alarm waste disposal.  Dice at §418.113(b)(6)(iii):] ures.  Padditional requirements for patient care facilities only.  Decedures must address the subsistence needs for and patients, whether they in place, include, but are not ng: medical, and pharmaceutical rees of energy to maintain the esto protect patient health he safe and sanitary storage lighting.  Den, extinguishing, and alarm waste disposal.  T is not met as evidenced view and staff interview, the provide documentation that aredness plan address	E	015	E 015 the Facility Administrator develop an EPP plan that will incomplete sewage and waste disposal servitor the building. The Facility has generator power and we have platent's health and safety and for safe and sanitary storage of provisions.  (b) Emergency lighting (c) Fire Detection, Extinguishing and alarm systems.  (d) Sewage and waste disposal And for in=-patient Hospice we will obtain food, Water, medical and Pharmacy supplies.  We have alternate sources energy to keep Temperatures to protect patient health and safety and sanitary storage or provisions. The Administrator will in-service all staff and will take this to the QAPI meeting for approval. This will be a	elude ices lans y ng l e	5/31/19

The findings included:

permanent fix.

#### PRINTED: 05/23/2019 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 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH **GREENBRIER REGIONAL MEDICAL CENTER** CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION In (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 TAG DEFICIENCY) E 015 Continued From page 8 E 015 The facility emergency preparedness plan failed to have documentation of procedures or agreements for the provision of sewage and waste disposal services during an emergency. During a review of the emergency preparedness plan with the administrator on 4/11/19 at 3:55 P.M. The administrator was asked for documentation for procedures or vendor contracts for sewage and waste disposal services. The administrator stated "He did not have documentation of the facility having contract agreements for sewage and waste disposal services." The facility staff failed to provide documentation of procedures for sewage and waste disposal services. E 018 Procedures for Tracking of Staff and Patients E 018 SS=C CFR(s): 483.73(b)(2) [(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:]

(2) A system to track the location of on-duty staff and sheltered patients in the [facility's] care during an emergency. If on-duty staff and sheltered patients are relocated during the emergency, the [facility] must document the specific name and

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/23/2019 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 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH GREENBRIER REGIONAL MEDICAL CENTER CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) E 018 Continued From page 9 E 018 location of the receiving facility or other location. \*[For PRTFs at §441.184(b), LTC at §483.73(b), ICF/IIDs at §483.475(b), PACE at §460.84(b):] Policies and procedures. (2) A system to track the 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 communication with external sources of assistance. (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 the receiving facility or other location. \*IFor CMHCs at §485.920(b):] Policies and

assistance.

procedures. (2) Safe evacuation from the CMHC,

responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of

which includes consideration of care and treatment needs of evacuees; staff

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY
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NAME OF	PROVIDER OR SUPPLIER	1 43330	D. WING		REET ADDRESS, CITY, STATE, ZIP CODE	04	/16/2019
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	procedures. (2) A significant donor information, potential and actual secures and maintal actual a	is staff responsibilities, and staff interview, the provide documentation for ents at alternate sites. The ride documentation that staff and sheltered patients ed during an emergency on 04/11/19 at 4:05 P.M. the sked to provide	EC	)18			
Commence of the Commence of th	documentation that on the facility's syste on-duty staff and sh relocated during an administrator stated staff on the tracking nursing staff they we	facility staff have been trained em to track the location of eltered resident who are			permanent fix.		5/31/19

#### PRINTED: 05/23/2019 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 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH GREENBRIER REGIONAL MEDICAL CENTER CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY E 018 | Continued From page 11 E 018 and staff during an emergency in the event residents are relocated. The staff stated, they had not received training. The facility staff failed to train staff on the system to track the location of on-duty staff and sheltered residents who are relocated during an emergency. Policies for Evac. and Primary/Alt. Comm. E 020 E 020 SS=C CFR(s): 483.73(b)(3) (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:1 Safe evacuation from the [facility], which includes consideration of care and treatment needs of evacuees; staff responsibilities; transportation; identification of evacuation location(s); and primary and alternate means of communication with external sources of assistance. \*[For RNHCs at §403.748(b)(3) and ASCs at §416.54(b)(2):1

includes the following:

(ii) Staff responsibilities.(iii) Transportation.

Safe evacuation from the [RNHCl or ASC] which

(i) Consideration of care needs of evacuees.

(iv) Identification of evacuation location(s).(v) Primary and alternate means of

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					1017 GEORGE WASHINGTON HIGHWAY NO	F1.771 4	
GREENE	BRIER REGIONAL ME	DICAL CENTER		ŧ		RIH	
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(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	communication with assistance.  * [For CORFs at §44 Rehabilitation Agence §485.727(b)(1), and §494.62(b)(2):] Safe evacuation from Rehabilitation Agencies as Provided Therapy and Speech Services; and ESRE staff responsibilities,  * [For RHCs/FQHCs evacuation from the appropriate placemer responsibilities and in This REQUIREMEN by: Based on record revision facility staff failed to emergency prepared and procedures for the facility.  The findings included the administrator, he documentation for the facility including care transportation, identification and alternate with external resource.	external sources of  35.68(b)(1), Clinics, cies, OPT/Speech at ESRD Facilities at  In the [CORF; Clinics, cies, and Public Health ers of Outpatient Physical In-Language Pathology Facilities], which includes and needs of the patients.  It §491.12(b)(1):] Safe RHC/FQHC, which includes ent of exit signs; staff needs of the patients.  It is not met as evidenced  wiew and staff interview, the have documentation that the liness plan included policy he safe evacuation from the  d:  In 4/11/19 at 11:15 A.M with was asked for e safe evacuation from the for the residents, fication of evacuation e means of communication es and staff responsibilities.	E	020			5/31/19
and a second sec	facility which included transportation needs,	care for residents, communication with					

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/23/2019

**FORM APPROVED** 

#### PRINTED: 05/23/2019 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 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH GREENBRIER REGIONAL MEDICAL CENTER CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID. (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) E 020 Continued From page 13 E 020 external resources and staff responsibilities. The facility staff failed to have documentation that the emergency preparedness plan included policy and procedures for the safe evacuation from the facility. E 022 Policies/Procedures for Sheltering in Place E 022 CFR(s): 483.73(b)(4) SS=C ((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 E 022 The Facility address the following:) Administrator will develop an (4) A means to shelter in place for patients, staff, EPP that will address to and volunteers who remain in the [facility]. [(4) or protect the confidentiality of (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the Patient information and facility). maintain the availability of \*[For Inpatient Hospices at §418.113(b):] Policies resident records to support and procedures. the continuity of care for (6) The following are additional requirements for Residents during an hospice-operated inpatient care facilities only.

followina:

The policies and procedures must address the

(i) A means to shelter in place for patients,

hospice employees who remain in the hospice. This REQUIREMENT is not met as evidenced

Based on record review and staff interview, the facility staff failed to have documentation for

emergency. All staff will be

trained on the EPP plan and

will be taken to our QAPI

meeting for review and

approval. This will be a

permanent fix.

5/31/19

#### PRINTED: 05/23/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING \_\_\_\_\_ С 495330 B. WING \_ 04/16/2019 NAME OF PROVIDED OR SHOPLIE

NAME OF	PROVIDER OR SUPPLIER	<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	11012019
GREEN	BRIER REGIONAL MEDICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 023 SS=C	sheltering in place.  The findings included:  During an interview with the administrator on 4/11/19 at 11:24 A.M. the administrator was asked for documentation for the process of sheltering in place for staff, volunteers and visitors. The administrator stated, he did not have documentation for sheltering in place for staff, volunteers and visitors.  The facility staff failed to have procedure documentation for sheltering in place for staff, volunteers and visitors.  Policies/Procedures for Medical Documentation	E 02		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
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E 023	Continued From pa *[For RNHC s at §4 procedures. (5) A sy that does the follow (i) Preserves patien (ii) Protects confide (iii) Secures and ma records.  *[For OPOs at §486 procedures. (2) A sy documentation that donor information, p potential and actual secures and mainta This REQUIREMEN by: Based on record re facility staff failed to verification system f information.  The findings include  During an interview the administrator, he documentation of the plan to protect confici information and mai resident records. Th not have documenta were secure and rea continuity of care for emergency.  The facility staff faile preserving resident i	ge 15 03.748(b):] Policies and ystem of care documentation ing: t information. Initiality of patient information, and instem of medical preserves potential and actual protects confidentiality of donor information, and instem availability of records. It is not met as evidenced view and staff interview, the have a documentation or preserving patient in the availability of emergency preparedness dentiality of patient intain the availability of eadministrator stated, he diduction to ensure patient records adily available to support the residents during an information.	PREFI TAG	023	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE RIATE	COMPLETION DATE

AND PLAN OF CORRECTION DENTIFICATION NUMBER:  A. BUILDING COM	E SURVEY PLETED C 16/2019
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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAY NORTH  CHESAPEAKE, VA 23323	
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[(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) 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:]  (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency and other emergency staffing strategies to address surge needs during an emergency.  *[For Hospice at §418.113(b):] Policies and procedures. (4) The use of hospice employees in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency.  This REGUIREMENT is not met as evidenced by:  Based on record review and staff interview, the facility staff falled to develop policies and procedures for the use of volunteers during an emergency.	5/31/19

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i i		E CONSTRUCTION	(X3) DAT	E SURVEY MPLETED
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E 024	The findings included During an interview with the Administrativolunteers who assist the facility had not describe the facilit	on 04/11/19 at 11:55 A.M. or he stated, the facility have st residents daily, however, eveloped policies and use of volunteers during	EC	)24			
E 025 SS=C	procedures for the usemergency. Arrangement with OCFR(s): 483.73(b)(7)  [(b) Policies and proceduplan set forth in paragand the communication this section. The policies and update minimum, the policies	cedures. The [facilities] must ent emergency preparedness ures, based on the emergency graph (a) of this section, risk graph (a)(1) of this section, ion plan at paragraph (c) of icies and procedures must be ed at least annually. At a	ΕO	25			
THE REAL PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS	Facilities at §483.73(7) [or (5)] The devel other [facilities] [and] patients in the event operations to mainta to facility patients.  *[For PACE at §460.8§483.475(b), CAHs a	18.113(b), PRFTs at als at §482.15(b), and LTC (b):] Policies and procedures, opment of arrangements with other providers to receive of limitations or cessation of in the continuity of services				ADDRESS (A SAME A SAME ) THE SAME ASSESSMENT ASSESSMENT ASSESSMENT ASSESSMENT ASSESSMENT ASSESSMENT ASSESSMENT	

STATEMENT OF DEFICIENCIES

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	development of arr [facilities] [or] other in the event of limit operations to main to facility patients.  *[For RNHCIs at §4 procedures. (7) The arrangements with providers to receive limitations or cessa the continuity of no patients. This REQUIREMENT by: Based on record re facility staff failed to based on the emery make arrangements providers.  The findings include During an interview with the administrate and procedures for facility's and provide event of limited or c The administrator si and procedures, no with other facility's for residents during an arise.  The facility staff faile	dures. (7) [or (6), (8)] The rangements with other providers to receive patients ations or cessation of tain the continuity of services  103.748(b):] Policies and edvelopment of other RNHCIs and other expatients in the event of tion of operations to maintain numedical services to RNHCI.  In it is not met as evidenced eview and staff interview the have policies and procedures gency preparedness plan to swith other facility's and other exists or experiences with other exists or receive residents in the essation of operations. The transfer or receiving of emergency should the need end to have policy's and crearrangement of transfer.	EO	025	E 025 The Facility did Show that we had at One transfer agreement with a Sister Facility 2 hours away in Tappahannock VA. We will develop additional transfer agreements with local SNFs and others that are further away incase of hurricane or other disasters and we need to get our Residents to a safer location not in our immediate area. Staff will be trained on this as well. We will take it to our QAPI committee meeting for review and approval. This will be a permanent fix.		5/31/19	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/23/2019 **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 \_ 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH GREENBRIER REGIONAL MEDICAL CENTER CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE 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 **DEFICIENCY** E 026 Continued From page 19 E 026 E 026 Roles Under a Waiver Declared by Secretary E 026 CFR(s): 483.73(b)(8) [(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:) (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate E 026 The Facility will care site identified by emergency management develop the EPP plan that officials. will have a clear \*[For RNHCIs at §403.748(b):] Policies and understanding of our Staff procedures. (8) The role of the RNHCl under a providing care for our waiver declared by the Secretary, in accordance Residents if we have to with section 1135 of Act, in the provision of care at an alternative care site identified by emergency evacuate and send staff to management officials, Facilities / alternate care This REQUIREMENT is not met as evidenced sites in other locations. Staff Based on record review and staff interview the will be trained on the policy facility staff failed to have documentation and procedures for this and describing the facilities role in providing care in an

alternate care site.

The findings included:

During an interview with the administrator on

04/12/19 at 9:51 a.m., the administrator and the Regional Director of Operations were asked for

we will take it to our QAPI committee meeting for

review and approval. This

will be a permanent fix.

5/31/19

STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
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GREEN	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGH CHESAPEAKE, VA 23323	WAY NORTH	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
SS=C	documentation descriproviding care at an administrator stated documentation described care that would be partially and as on providing care at staff response was, were they aware of care site in the ever residents had to be.  The facility staff failed describing the facility alternate care site.  Development of Cornor CFR(s): 483.73(c).  (c) The [facility] must emergency prepared that complies with Frand must be reviewed annually.  This REQUIREMEN by:  Based on record refacility staff failed to information in the control of the administrator, he contact information fentities providing ser during an emergency document of the entities providing ser during an emergency document of the entities providing ser during an emergency document of the entities providing ser during an emergency document of the entities providing ser during an emergency document of the entities providing ser during an emergency document of the entities providing ser during an emergency document of the entities providing ser during an emergency document at a series of the entities providing ser during an emergency document at a series of the entities providing ser during an emergency document at a series of the entities of the	cribing the facility's role in alternate care site. The he did not have any cribing the facility's role or the provided at an alternate care off were interviewed on 4/11/19 ked if they had been trained an alternate care site and the "No one trained them nor providing care at an alternate at of an emergency and moved."  The detailed the providing care in an an alternate in providing care in an alternate in an alternate in an alternate in an alternate in alternate in an alternate care site and the "I alternate in an alternate care site and the "I alternate in an alternate care site and the "I alternate in an alternate care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate care site and the providing care site and the "I alternate	E 02	E 029 The Facility did ha phone list which was sh the Surveyor, The Facili will continue to have a phone list and we will update it as needed wit	nown ity staff th taff e med. ation th l ed	6/1/19
					·	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/23/2019 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 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH **GREENBRIER REGIONAL MEDICAL CENTER** CHESAPEAKE, VA 23323 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 029 Continued From page 21 E 029 of all staff and their contact information; nor did the plan include vendors providing services to the facility during an emergency. The facility staff failed to have all facility contact information in the communication plan. E 030 Names and Contact Information E 030 CFR(s): 483.73(c)(1) SS=C [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:1 (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Patients' physicians (iv) Other [facilities]. (v) Volunteers. \*[For RNHCIs at §403.748(c):] The communication plan must include all of the following: (1) Names and contact information for the following: (i) Staff. (ii) Entities providing services under arrangement. (iii) Next of kin, guardian, or custodian. (iv) Other RNHCIs.

\*[For ASCs at §416.45(c):] The communication

plan must include all of the following: (1) Names and contact information for the

(v) Volunteers.

DEPAR CENTE	TMENT OF HEALT RS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/23/2019 APPROVED 0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495330	B. WING				C
NAME OF	PROVIDER OR SUPPLIEF			ST	REET ADDRESS, CITY, STATE, ZIP CODE	04	/16/2019
GREEN	BRIER REGIONAL MI	EDICAL CENTER	*	101	17 GEORGE WASHINGTON HIGHWAY NO HESAPEAKE, VA 23323	PRTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BF	(X5) COMPLETION DATE
	following: (i) Staff. (ii) Entities providing (iii) Patients' physically Volunteers.  *[For Hospices at & communication plate following: (1) Names and confollowing: (i) Hospice employed (ii) Entities providing (iii) Patients' physically Other hospices  *[For HHAs at &484 plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physically Volunteers.  *[For OPOs at &486 plan must include at (1) Names and confollowing: (i) Staff. (ii) Entities providing (iii) Patients' physically Volunteers.	ig services under arrangement. cians.  3418.113(c):] The in must include all of the itact information for the ees. ig services under arrangement. ians.  3.102(c):] The communication ill of the following: intact information for the ig services under arrangement. ians.  3.360(c):] The communication	ΕO	30	E 030 The Facility did have a phone list which was shown the Surveyor, The Facility will continue to have a staff phone list and we will update it as needed with new staff numbers or staff that change their phone number as we are informed. The Administrator will develop the communication plan that will comply with Federal, State, and local laws and will be reviewed		

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

(iii) Volunteers.

by:

(iv) Other OPOs.

Donation Service Area (DSA).

(v) Transplant and donor hospitals in the OPO's

This REQUIREMENT is not met as evidenced

Based on record review and staff interview, the facility staff failed to have all facility contact

Event ID:EQPC11

Facility ID: VA0043

Include

and updated at least

annually. We will provide

training to all Staff. Our

communication plan will

If continuation sheet Page 23 of 147

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MAY 2 8 2019

	IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
	495330	B. WING			04	C
NAME OF PROVIDER OR SUPPLI	ER	<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04	/16/2019
GREENBRIER REGIONAL				017 GEORGE WASHINGTON HIGHWAY NO HESAPEAKE, VA 23323	RTH	•
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
The findings included by the administration and contact information as entities provided during an emergence communications all staff and their plan include vene facility during an an arrow of the facility staff of the facility staff of the facility staff of the facility of the facilities of	ever on 04/12/19 at 10: 33 a.m. rator, he was asked for names mation for all facility staff, as welling services under agreement ency. A review of the plan did not include the name of contact information. Nor did the dors providing services to the emergency.  ailed to have all facility contact communication plan. (als Contact Information e)(2)  must develop and maintain an aredness communication plan in Federal, State and local laws ewed and updated at least immunication plan must include g:  nation for the following: te, tribal, regional, and local redness staff. es of assistance.  es at §483.73(c):] (2) Contact et following: tribal, regional, or local	E 03		1), Staff names and contract information Staff 2). Entities providing services under the arrangement 3), Patients Physicians 4). Other Facilities 5). Volunteers We will take our communication plan to our QAPI meeting for review and approval. This will be a permanent fix.		5/31/19

		AND HUMAN SERVICES & MEDICAID SERVICES			1	<b>FORM</b>	: 05/23/2019 APPROVED	)
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			X3) DAT	. 0938-0391 E SURVEY IPLETED	_
		495330	B. WING	i			C <b>16/2019</b>	
NAME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2013	-
GREEN	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NORT CHESAPEAKE, VA 23323	ТН		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	*
E 033 SS=C	(iv) Other sources of  *[For ICF/IIDs at §4! information for the fi (i) Federal, State, tri emergency prepared (ii) Other sources of (iii) The State Licens (iv) The State Protect This REQUIREMEN by: Based on record refacility staff failed to information for source communication plan  The findings include  During an interview of with the administrator and contact informat services under agree The administrator pr department names afederal, state, tribal a preparedness staff, plan did not include of the facility during an  The facility staff faile information in the con Methods for Sharing CFR(s): 483.73(c)(4)  [(c) The [facility] must emergency prepared	If assistance.  B3.475(c):] (2) Contact ollowing: bal, regional, and local dness staff. assistance. Sing and Certification Agency. It is not met as evidenced view and staff interview, the have all required contact ces of assistance in the driving an emergency. It is not met as evidenced view and staff interview, the have all required contact ces of assistance in the driving an emergency. It is not met as evidenced view and staff interview, the have all required contact ces of assistance in the driving an emergency. It is not met as asked for names asked for names asked for names are driving an emergency. It is not met all facility contact met all facility contact method in the vendors providing services to emergency. It do have all facility contact method in the vendors providing name and the vendors and maintain an interest communication plan.	EO	33	E 031 The Facility Administrator will develop an EPP plan communication plan that complies with Federal, State, and Local Laws and will be reviewed and updated at least annually. The Facilities communication plan will include a method for sharing information and medical documentation to maintain continuity of care. All staff will be trained on the communication and their roles in a disaster and the chain of command. The communication plan also will be taken to our QAPI meeting and reviewed and approved. This is a permanent fix.		5/31/19	
THE VITE SHEET AND SHEET A	emergency prepared that complies with Fe	t develop and maintain an ness communication plan ederal, State and local laws d and updated at least						

AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION (X3)		ATE SURVEY OMPLETED
		495330	B. WING	ì		٥	C 4/16/2019
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME				STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		7 10/2019
(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	(XS) COMPLETION DATE
	(4) A method for sha documentation for p care, as necessary, maintain the continut (5) A means, in the release patient infor CFR 164.510(b)(1)(i required for HHAs u under §485.68(c), as §491.12(c).]  (6) [(4) or (5)]A mean about the general condition and representative.  *[For RNHCls at §40 sharing information and spatients under the R with care providers to care, based on the womade by the patient representative.  *[For RHCs/FQHCs are as permation and location facility's care as permatically as a patient of the patient of th	aring information and medical patients under the [facility's] with other health providers to nity of care.  Event of an evacuation, to mation as permitted under 45 ii). [This provision is not under §484.102(c), CORFs and RHCs/FQHCs under  This of providing information and location of acility's] care as permitted and (are documentation for NHCl's care, as necessary, or maintain the continuity of written election statement or his or her legal  at §491.12(c):] (4) A means ion about the general of patients under the nitted under 45 CFR  If is not met as evidenced iew and staff interview, the nave documentation that the included a method for	E	033			
	straring information a	nd medical documentation					

PRINTED: 05/23/2019 **FORM APPROVED** OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495330	B. WING		C 04/16/0010
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY N CHESAPEAKE, VA 23323	04/16/2019 Новтн
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	,	D BE COMPLETION
E 033	to maintain continui The findings include During an interview	ty of care. ed: on 04/12/19 at 10:48 a.m.	E 0	)33	
	that the facility had a information and medother health care professed for the administration for some dical care needs care site.  The facility staff failed the communication	or, he was asked for evidence a method for sharing dical care for residents with oviders to maintain continuity strator stated, he did not have haring information and for residents in an alternate and to have documentation that plan included methods for			
SS=C	health care provider. Information on Occu CFR(s): 483.73(c)(7) [(c) The [facility] must emergency prepared that complies with Frand must be reviewed annually.] The commall of the following:  (7) [(5) or (6)] A mea about the [facility's] of ability to provide assonating jurisdiction, the Center, or designee.  *[For ASCs at 416.54]	st develop and maintain an dness communication plan ederal, State and local laws ed and updated at least nunication plan must include ans of providing information occupancy, needs, and its istance, to the authority ne Incident Command	E 0:	Administrator will develop a EPP communication plan providing information about our Occupancy, needs, and its ability to provide assistance to the Authority having jurisdiction, the incident Command Center of Designee. We will train all Staff and take the plan to out QAPI meeting for review and	r Ir 5/31/19
***************************************	its ability to provide a	n about the ASC's needs, and assistance, to the authority ne Incident Command		approval. This is a permaner fix.	it

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	,		CONSTRUCTION		TE SURVEY MPLETED
		495330	B. WING				C
	PROVIDER OR SUPPLIER  BRIER REGIONAL MEI			ST1	REET ADDRESS, CITY, STATE, ZIP CODE 17 GEORGE WASHINGTON HIGHWAY NO IESAPEAKE, VA 23323		J/16/2019
(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 DATE
E 034	Center, or designee  *[For Inpatient Hosp of providing informa inpatient occupancy provide assistance, jurisdiction, the Incid designee. This REQUIREMEN by: Based on record refacility staff failed to the facility's occupar provide assistance.  The findings include  During an interview of with the administrate documentation for id facility, including the	dice at §418.113:] (7) A means tion about the hospice's needs, and its ability to to the authority having lent Command Center, or T is not met as evidenced view and staff interview, the have documentation about ney needs and its ability to d:  on 04/12/19 at 12:06 P.M. or, he was asked for tentifying the needs of the residents as well as the	E 03	34			
E 035 SS=C	Incident Command C stated, the facility ha the residents nor had the facility could prove The facility staff faile and have means of p the facility's needs an assistance. LTC and ICF/IID Sha CFR(s): 483.73(c)(8) [(c) The [LTC facility and maintain an eme- communication plan	d to provide documentation providing information about a dits ability to provide	E 03	5			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DAT COM	E SURVEY MPLETED
		495330	B. WING				C <b>16/2019</b>
	PROVIDER OR SUPPLIER BRIER REGIONAL ME			1017	EET ADDRESS, CITY, STATE, ZIP CODE GEORGE WASHINGTON HIGHWAY NO SAPEAKE, VA 23323		10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 035	updated at least an plan must include at (8) A method for shemergency plan, the is appropriate, with families or represent This REQUIREMENT by:  Based on record refacility staff failed to information of the Ewith residents and formation and interview with the administrate facility shared emerinformation with resadministrator stated notices but could not asked how did he keadministrator stated information to confind been notified all preparedness plan.	nually.] The communication all of the following:  aring information from the at the facility has determined residents [or clients] and their natives.  It is not met as evidenced eview and staff interview, the have a method for sharing emergency Preparedness Plan families.  It is not met as evidenced eview and staff interview, the have a method for sharing emergency Preparedness Plan families.  It is not met as evidenced eview and staff interview, the have a method for sharing emergency Preparedness Plan families.  It is not met as evidenced eview and staff interview, the have a method for sharing emergency preparedness idents and families. The did not have any methat residents or families bout the emergency	EO		E 035 The Facility Administrator will develop ar EPP plan that will develop a way that we can inform our Residents and their families about our EPP plan and how it will affect them. Notices were sent out and will be sent out again to meet this section of the Federal and State and Local Laws.  Staff will be trained and the EPP plan for communicating with the Residents and Families will be taken to the QAPI meeting for review and approval. At least annually and updated. This will be a permanent fix		5/31/19
			E 03	36			
H KAPPARE GERMAN TA DER KANDE KANDE KANDE KERTER KERTER KERTER KERTER KERTER KERTER KERTER KERTER KERTER KERTE	develop and mainta preparedness trainii	ting. The [facility] must in an emergency ng and testing program that is jency plan set forth in					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i .		LE CONSTRUCTION		TE SURVEY MPLETED
		495330	B. WING			i .	C / <b>16/2019</b>
	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		10/2013
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 036	paragraph (a)(1) of procedures at parathe communication section. The training be reviewed and up "[For ICF/IIDs at §4 testing. The ICF/IID an emergency preparament that is baseforth in paragraph (assessment at parapolicies and proced section, and the comparagraph (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 emergency plan set section, and orientation program emergency plan set section, policies (b) of this section, a paragraph (c) of this and orientation program that it is section, a paragraph (c) of this section, a paragraph (d) of this section, a paragraph (e) of this section, a paragraph (f) of this section, a paragraph (g) of this section (g) o	this section, risk assessment at this section, policies and graph (b) of this section, and plan at paragraph (c) of this ag and testing program must odated at least annually.  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 mmunication plan at a section. The training and st be reviewed and updated at ICF/IID must meet the acuation drills and training at es at §494.62(d):] Training, ion. The dialysis facility must in an emergency and patient that is based on the forth in paragraph (a) of this ment at paragraph (a) of this ment at paragraph (a)(1) of and procedures at paragraph and the communication plan at a section. The training, testing arm must be reviewed and	EO	136	E 036 The Facility Administrator will develop an EPP and maintain an EPP plan for training and testing program that is based on the EPP plan. This will be updated and reviewed at least annually. This training and testing plan will be taken to our QAPI meeting for review and approval. Staff will be trained with said plan. This is a permanent fix		5/31/19

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495330		B. WING			C	
NAME OF PROVIDER OR SUPPLIER			ـــــا		STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	/16/2019
GREENBRIER REGIONAL MEDICAL CENTER							
					1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID.		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFI TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
E 036	Continued From page 30 The findings included:		ΕC	136			-
				-00			
	ino mango moidae						
	During an interview on 04/12/19 at 12:17 P.M. with the administrator, he was asked for documentation of the facility's training and testing program. The administrator stated, the facility had						The second state of the se
	not developed a training and testing program.						
	The facility staff failed to have a training and						7
F 007	testing program.			i			<b>!</b> !
	EP Training Program		ΕO	37			
SS=C	CFR(s): 483.73(d)(1)						
Production and the structure of the stru	ASCs, PACE organia	The [facility, except CAHs, zations, PRTFs, Hospices, must do all of the following:					
	policies and procedu staff, individuals prov	mergency preparedness ires to all new and existing viding services under olunteers, consistent with their					
***************************************		cy preparedness training at					
ĺ		entation of the training.		-			
	(iv) Demonstrate sta	ff knowledge of emergency				:	
1	procedures.						
	at §491.12:] (1) Train	82.15(d) and RHCs/FQHCs ling program. The [Hospital do all of the following:					
	(i) Initial training in er	nergency preparedness		HARMAN			
	policies and procedu	res to all new and existing		į			
	staff, individuals prov	riding on-site services under		***************************************			
	arrangement, and volunteers, consistent with their expected roles.					ļ	ĺ
				1			
	(ii) Provide emergend	cy preparedness training at		**********			
	least annually.	_		Willes To Service Street			
(iii) Maintain doc		ntation of the training.					
	**************************************			T Value			ļ

(X2) MULTIPLE CONSTRUCTION

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495330	B. WING	S			C	
NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER				STREET ADDRESS, CITY, STAT 1017 GEORGE WASHINGTO CHESAPEAKE, VA 23323	04/16/2019 RTH			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)		BE COMPLE	ETION		
	*[For Hospices at §4-hospice must do all (i) Initial training in expolicies and procedures are expected roles. (ii) Demonstrate states procedures. (iii) Provide emerger least annually. (iv) Periodically revidement procedures including special emphasis play procedures necessate others.  *[For PRTFs at §441 program. The PRTF (i) Initial training in expolicies and procedustaff, individuals prove arrangement, and volume expected roles. (iii) Demonstrate states procedures. (iv) Maintain docume preparedness training freparedness	A18.113(d):] (1) Training. The of the following: emergency preparedness ures to all new and existing and individuals providing ngement, consistent with their off knowledge of emergency ncy preparedness training at ew and rehearse its dness plan with hospice g nonemployee staff), with aced on carrying out the ary to protect patients and all of the following: mergency preparedness ures to all new and existing viding services under plunteers, consistent with their g, provide emergency g at least annually. If knowledge of emergency entation of all emergency g.  B4(d):] (1) The PACE	E	037				
DRM CMS-256	7(02-99) Previous Versions O	bsolete Event ID: EQPC11		Facility ID: VA0043	If continuation of			

Facility ID: VA0043

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If continuation sheet Page 32 of 147

MAY 28 2019

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
495330			8. WING			C 04/16/2019		
NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER				10	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	PRESS, CITY, STATE, ZIP CODE GE WASHINGTON HIGHWAY NORTH		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)			(X5) COMPLETION DATE	
	policies and proced staff, individuals pro arrangement, contra volunteers, consiste (ii) Provide emerger least annually. (iii) Demonstrate sta procedures, includir what to do, where to case of an emergen (iv) Maintain docume '[For CORFs at §48 CORF must do all o (i) Provide initial train preparedness policies and existing staff, in under arrangement, with their expected releast annually. (iii) Maintain docume (iv) Demonstrate sta procedures. All new and assigned specifithe CORF's emergentheir first workday. Tinclude instruction in alarm systems and sequipment.  *[For CAHs at §485.4] The CAH must do al (i) Initial training in expolicies and procedure protring and extinguand where necessary	ures to all new and existing viding on-site services under actors, participants, and ent with their expected roles. Incy preparedness training at aff knowledge of emergency ag informing participants of go, and whom to contact in acy. Incompared training.  5.68(d):](1) Training. The fine following: In emergency es and procedures to all new dividuals providing services and volunteers, consistent coles. Incy preparedness training at entation of the training. In the fine following training at entation of the training ency personnel must be oriented in the training program must the location and use of signals and firefighting.	EO	37				

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/23/2019

FORM APPROVED

#### PRINTED: 05/23/2019 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 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH GREENBRIER REGIONAL MEDICAL CENTER CHESAPEAKE, VA 23323 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION m (X5) COMPLETION PRÉFIX (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 DATE DEFICIENCY) E 037 Continued From page 33 E 037 cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. \*[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency E 037 The Facility procedures. Thereafter, the CMHC must provide emergency preparedness training at least Administrator will develop an annually. EPP plan that maintains an EPP plan for training and This REQUIREMENT is not met as evidenced testing program that is based Based on record review and staff interview the upon EPP plan. This will be facility staff failed to have an initial emergency updated and reviewed preparedness training and testing program.

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

and testing program.

The findings included:

During an interview on 04/12/19 at 12: 17 P.M.

The facility staff failed to have an initial training

documentation of the facilities training and testing

program. The administrator stated, the facility had not developed a training and testing program.

with the administrator, he was asked for

Event ID: EQPC11

Facility ID: VA0043

annually. This training and

testing plan will be taken to

our QAPI meeting for review

and approval. Staff will be

trained with said plan. This

will be a permanent fix.

If continuation sheet Page 34 of 147

5/31/19

DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				FORM	D: 05/23/2019 MAPPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CIPLE CONSTRUCTION  NG	(X3) DA	). 0938-0391 TE SURVEY MPLETED
		495330	B. WING	}		04	C / <b>16/2019</b>
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	DICAL CENTED			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO		71072019
GILLIN			*****	L	CHESAPEAKE, VA 23323		
(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 SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 039 SS=C	EP Testing Require CFR(s): 483.73(d)(2		E	<b>3</b> 3:	99		
	RNHCIs and OPOs test the emergency	ility, except for LTC facilities,   must conduct exercises to plan at least annually. The NHCIs and OPOs] must do					
	The LTC facility must the emergency plan unannounced staff of	at §483.73(d):] (2) Testing. It conduct exercises to test at least annually, including frills using the emergency C facility must do all of the					The state of the s
	community-based or exercise is not access facility-based. If the actual natural or mai requires activation or [facility] is exempt from community-based or full-scale exercise for the actual event.  (ii) Conduct an additinclude, but is not lim  (A) A second full-scommunity-based or (B) A tabletop exediscussion led by a facilinically-relevant emory problem statement prepared questions community based.	[facility] experiences an n-made emergency that f the emergency plan, the orn engaging in a r individual, facility-based or 1 year following the onset of tonal exercise that may					

exercises, and emergency events, and revise the

[facility's] emergency plan, as needed.

STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495330	B. WING			Ĭ	C 16/2019	
	PROVIDER OR SUPPLIER RIER REGIONAL ME	DICAL CENTER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		10/2013	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
E 039	§486.360] (d)(2) Termust conduct exerciplan. The [RNHCl at following: (i) Conduct a paper least annually. A take discussion led by a clinically relevant error problem stateme prepared questions emergency plan. (ii) Analyze the [RN to and maintain doc exercises, and eme [RNHCl's and OPO' needed. This REQUIREMEN by: Based on record refacility staff failed to facility's emergency analysis and responsible.  The findings included During an interview with the administrated documentation of the analyses and the readministrator stated conduct an analysis did the facility staff repreparedness plan at the facility staff failed.	03.748 and OPOs at sting. The [RNHCl and OPO] ises to test the emergency and OPO] must do the r-based, tabletop exercise at oletop exercise is a group facilitator, using a narrated, nergency scenario, and a set at oletop exercise is a group facilitator, using a narrated, nergency scenario, and a set at oletop exercise messages, or designed to challenge an electron of all tabletop regency events, and revise the selementation of all tabletop regency events, and revise the selementation of the have documentation of the preparedness exercise section 04/12/19 at 12:25 P.M. or, he was asked for e facility's table top exercise vised emergency plan. The the facility staff did not of the table top exercise nor evise the emergency	EC	039	E 039 The Facility did have a table top exercise in August 2018 and will develop another one with the area EOC. This will be done in with local Fire department, EMS and other entities to comply with the requirements. This training will include staff as well. And we will take what we analysis what learned from this exercise and make adjustments to our EPP plan. This will a permanent fix		5/31/19	

(X2) MULTIPLE CONSTRUCTION

DEPAF CENTE	RTMENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES			FOR	D: 05/23/2019 MAPPROVED
Statemen	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		JETIPLE CONSTRUCTION DING	(X3) D.	O. 0938-0391 ATE SURVEY OMPLETED
		495330	B. WING	G	٥	C 4/16/2019
	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COE 1017 GEORGE WASHINGTON HIGHWA CHESAPEAKE, VA 23323	)E	4/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
E 041 E 041 SS=C	Continued From page Hospital CAH and L'CFR(s): 483.73(e)	ge 36 TC Emergency Power	1	041 041		
	nospital must impler power systems base forth in paragraph (a policies and procedu	standby power systems. The ment emergency and standby ed on the emergency plan set and in the gres plan set forth in and (ii) of this section.				
***************************************	emergency and stan	5(e) standby power systems. The CAH] must implement dby power systems based on set forth in paragraph (a) of				
	Emergency generato must be located in ac requirements found in Code (NFPA 99 and TAMENTA 12-5, and TIA 12-6), I and Tentative Interim 12-2, TIA 12-3, and T	2, TIA 12-3, TIA 12-4, TIA Life Safety Code (NFPA 101 Amendments TIA 12-1, TIA IA 12-4), and NFPA 110, is built or when an existing				
1 1 1	emergency generator hospital, CAH and LT he emergency power and maintenance requ	(e)(2), §485.625(e)(2) inspection and testing. The C facility] must implement system inspection, testing, airements found in the Code, NFPA 110, and Life			CONTRACTOR	

482.15(e)(3), §483.73(e)(3), §485.625(e)(3)

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/23/2019 **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 495330 B. WING 04/16/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH **GREENBRIER REGIONAL MEDICAL CENTER** CHESAPEAKE, VA 23323 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PRÉFIX (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**) E 041 Continued From page 37 E 041 Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. \*IFor hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(a):1 The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records

the changes.

Batterymarch Park,

1.617.770.3000.

Administration (NARA). For information on the availability of this material at NARA, call

http://www.archives.gov/federal\_register/code\_of

\_federal\_regulations/ibr\_locations.html.

If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce

(1) National Fire Protection Association, 1

(i) NFPA 99, Health Care Facilities Code, 2012

(ii) Technical interim amendment (TIA) 12-2 to

(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.(v) TIA 12-5 to NFPA 99, issued August 1, 2013.

Quincy, MA 02169, www.nfpa.org,

edition, issued August 11, 2011.

NFPA 99, issued August 11, 2011.

202-741-6030, or go to:

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDED (SUPPLIED COLD.)

	OF CORRECTION	IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495330	B. WING			04	C <b>I/16/2019</b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1 C X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRED TO THE APPROP	RTH N	(X5) COMPLETION DATE
	(vi) TIA 12-6 to NFF (vii) NFPA 101, Life issued August 11, 2 (viii) TIA 12-1 to NF 2011. (ix) TIA 12-2 to NFP 2012. (x) TIA 12-3 to NFP 2013. (xi) TIA 12-4 to NFP 2013. (xii) NFPA 110, Star Standby Power Syst TIAs to chapter 7, is This REQUIREMEN by: Based on record refacility staff failed to the facility will keep the and/or written agree source vendor during The findings include  During an interview of with the administrated documentation of ho kept operational duri written agreement we emergencies. The acceptance  Th	A 99, issued March 3, 2014. Safety Code, 2012 edition, 011. PA 101, issued August 11, A 101, issued October 30, A 101, issued October 22, A 101, issued October 22, adard for Emergency and ems, 2010 edition, including sued August 6, 2009. T is not met as evidenced view and staff interview, the have documentation of how the generator functional ment with an outside fuel g the emergency.  d: on 04/12/19 at 12:33 P.M. or he was asked for w the generator would be ng an emergency and/or for ith an outside fuel vendor for dministrator was not able to tract for an outside fuel	F 00		E 041 The Facility has a generator on premises. We have a generator company that services our unit and a fuel company that will provide us fuel. In the event of a disaster we would pre plan and get the generator topped off with fuel and have spare fuel in the event that our fuel source could not make it out to our Facility. We will have fuel that will last us up to 96 hours. We will put copies of our agreements in the EPP book and have them for proof of having them.  This is permanent fix.		5/31/19
	survey was conducte and 4/15/19 through	edicare/Medicaid standard d 04/10/19 through 04/12/19 4/16/19. Corrections are ace with 42 CFR Part 483		***************************************		Andrew Principles Control of the Con	

	OF CORRECTION	IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		OATE SURVEY OMPLETED
		495330	B. WING			C 04/16/2019
GREENE	PROVIDER OR SUPPLIER  BRIER REGIONAL MEI			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY I CHESAPEAKE, VA 23323	IORTH	14/10/2015
(X4) ID PREFIX TAG	(EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE
F 582 SS=D	Four complaints were survey.  The census in this 1 103 at the time of the consisted of 36 curred closed record review Medicaid/Medicare (CFR(s): 483.10(g)(17) The (i) Inform each Medicaid of (i) Inform each Medicaid of (ii) Inform each Medicaid of (ii) The items and senursing facility service for which the resider (B) Those other item facility offers and for charged, and the amservices; and (ii) Inform each Medicaid in §483.10(section.  §483.10(g)(18) The fresident before, or at periodically during the available in the facility services, including arcovered under Medicaility's per diem rate	Care requirements.  e survey/report will follow. re investigated during the  20 certified bed facility was e survey. The survey sample ent Resident reviews and 8 /s.  Coverage/Liability Notice 77)(18)(i)-(v)  facility must caid-eligible resident, in f admission to the nursing resident becomes eligible for ervices that are included in resume the State plan and at may not be charged; s and services that the which the resident may be ount of charges for those  caid-eligible resident when the items and services (g)(17)(i)(A) and (B) of this  acility must inform each the time of admission, and e resident's stay, of services y and of charges for those ny charges for services not lare/ Medicaid or by the	F O	This plan of correction is respectfully Submitted in response to deficiencies cited on 4/10/19 to 4/16/1 This plan of correction constitutes a written allegation of substantial	l t	
	.,					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495330	B. WING			C 04/15/2010				
NAME OF	PROVIDER OR SUPPLIER		L		ESS, CITY, STATE, ZIP CODE	04/	16/2019			
						DTI				
GREEN	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)						
F 000	Continued From pa Federal Long Term The Life Safety Coo Four complaints we survey.  The census in this 1 103 at the time of the consisted of 36 curre closed record review Medicaid/Medicare CFR(s): 483.10(g)(17) The (i) Inform each Mediwriting, at the time of facility and when the Medicaid of (A) The items and sonursing facility services for which the resider (B) Those other item facility offers and for charged, and the am services; and (ii) Inform each Medicaid in §483.10 section. §483.10(g)(18) The fresident before, or as	ge 39 Care requirements.  le survey/report will follow. re investigated during the  20 certified bed facility was le survey. The survey sample ent Resident reviews and 8 vs. Coverage/Liability Notice 7)(18)(i)-(v)  facility must- caid-eligible resident, in f admission to the nursing resident becomes eligible for ervices that are included in ces under the State plan and and may not be charged; les and services that the which the resident may be lount of charges for those  icaid-eligible resident when to the items and services (g)(17)(i)(A) and (B) of this  facility must inform each the time of admission, and	F 58	F582 Med /Liability  1. R  a  (A)  P  w  1  itl  is	dicaid/ Medicare Covera Notice Resident #38 and or the Responsible party will be an Advanced Beneficiary ABN) letter for the Medi Part A stay starting 12-6- vith the last covered day 1-18-19. Resident #94 an he Responsible party will ssued an ABN letter for the Medicare Part A stay star	e issued Notice icare 18 y being nd or II be the rting 3-	ſ			
	available in the facilii services, including a covered under Medio facility's per diem rat	e resident's stay, of services y and of charges for those ny charges for services not care/ Medicaid or by the e. coverage are made to items			.5-19 with the last cover being 4-3-19.	ea uay				

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2	TIPLE CONSTRUCTION ING	(X3)	(X3) DATE SURVEY COMPLETED	
		495330	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIF	CODE	04/16/2019	
	·		1	1017 GEORGE WASHINGTON HIG		:	
GREENE	BRIER REGIONAL ME	EDICAL CENTER		CHESAPEAKE, VA 23323	ATTAL NORTH	·	
(X4) ID		ATEMENT OF DEFICIENCIES	DI	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLETIC	
F 582	Continued From pa	age 40	F 5	82			
		ed by Medicare and/or by the	. 0				
	Medicaid State plan	n, the facility must provide		İ			
	notice to residents	of the change as soon as is					
	reasonably possible			2. All Medicare Part	A covered		
	(ii) Where changes	are made to charges for other		residents have the	potential to	,	
	items and services	that the facility offers, the		be affected. All up		All the second s	
	facility must inform	the resident in writing at least		Medicare Part A d	_		
	(iii) If a resident die	plementation of the change. s or is hospitalized or is		be discussed in the		"	
1	transferred and doe	es not return to the facility, the		į.	-	ļ	
	facility must refund	to the resident, resident		meetings. Two day	-	1	
	representative, or e	state, as applicable, any		discharge an ABN		1	
	deposit or charges	already paid, less the facility's		issued by the Socia	l Worker. In		
	per diem rate, for th	ne days the resident actually		the absence of the	Social	,	
į	facility regardless	or retained a bed in the of any minimum stay or		Worker, the Admir			
į	discharge notice re	nuiremente				ĺ	
1	(iv) The facility mus	t refund to the resident or		designate who will	issue the		
	resident representa	tive any and all refunds due		ABN letter.			
:	the resident within 3	30 days from the resident's		3. The members of th	e IDT team		
ļ	date of discharge fr	om the facility.		will be in-serviced o	on ABN		
	(v) The terms of an	admission contract by or on		letters and when to		1	
		ual seeking admission to the		ž			
	tacility must not cor	flict with the requirements of		4. Weekly audits will t			
	these regulations.	IT is not met as evidenced		conducted X 4 weel	ks and then		
Ì	by:	vi is not met as evidenced		on a quarterly basis	. Results of		
		ecord review, staff interviews		all reviews and audi	ts will be		
1	and facility docume	ntation review, the facility staff		incorporated into th			
į	failed to ensure Med	dicare Beneficiary Notices in		1		1 .	
	accordance with ap	plicable Federal regulations.		QAPI process to ens			
	were issued to 2 of	3 discharged residents		compliance is achiev	ed and		
	(Resident #38 and #	f94) in the survey sample.		sustained.			
	1. The facility staff fa	ailed to issue an Advanced					
	Beneficiary Notice (	ABN) letter to Resident #38				-	
	who was discharged	from skilled services with				***	
	Medicare days rema	aining.		4			

RECEIVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED		
		495330	B. WING	à		l	С
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME			STREET ADDRESS, CITY, STATE, ZIP CO 1017 GEORGE WASHINGTON HIGHW CHESAPEAKE, VA 23323			/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORFIX (EACH CORRECTIVE ACTION S	HOULD	BE	(X5) COMPLETION DATE
	Beneficiary Notice (who was discharged Medicare days remainded Medicare days of her Medicare Part Medicare Part Medicare Part Medicare Part Medicare Part Medicare Medicare Part Medicare Part Medicare Part Medicare Medicare Part Medi	ailed to issue an Advanced ABN) letter to Resident #94 of from skilled services with aining.  It is re-admitted to the nursing Diagnosis for Resident #38 ted to Muscle Weakness. In mum Data Set (MDS) with an ince Date (ARD) date of ident #38 a 15 out of a on the Brief Interview for an on the Brief Interview for an on the surveyor it was #38 was not listed for having ABN (Skilled Nursing eneficiary Notice, form esident had received a Medicare Provider CMS-10123), however no BN (CMS-10055) were  If a Medicare Part A stay on the covered day of this stay dent #38 was discharged a services when benefit days and should have been issued 2055) and an NOMNC dent #38 had only used 44 as Part A services. Only an with written notification to	F 5	582			
		- I de la company de la compan				1	1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495330	B. WING	i			0
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIF		04/	16/2019
GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIG CHESAPEAKE, VA 23323		нтғ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD E HE APPROPRI	BE	(X5) COMPLETION DATE
	An interview was co Social Worker on Op.m., stated, "I did r letters until January was the Social Work The Assistant Social to locate an ABN let have no idea what a 2. Resident #94 was facility on 03/15/19. included but not limit Resident #94's Minit (ARD) date of 03/22 out of a possible social to the social moderate cognitive. On review of the Bell provided by the facil Resident #94 was not issued the SNF ABN Facility-Advanced Brown Common (Notice of Non-Coverage-form copies of the SNF ABN Facility-Advanced Brown Copies of the SNF ABN Facility-Advanced Brown Copies of the SNF ABN Facility-Advanced Brown Copies of the SNF ABN (CMS-10055). The resident #94 started 03/15/19, and the last was 04/03/19. Resident #94 started 03/15/19.	anducted with the Assistant 4/09/19 at approximately 4:00 not starting issuing the cut 19, 2019 and before then it ker who is no longer here. If Worker stated, "I was unable ter for Resident #38; I really in ABN letter is."  Is admitted to the nursing Diagnosis for Resident #94 ted to Respiratory Failure. Image and the property of 15 on the Brief Status (BIMS) that indicated impairment.  Ineficiary Notification Checklist ity to surveyor was noted that of listed for having been I (Skilled Nursing eneficiary Notice, form esident had received a	F	582			
1	was issued, with writ #94 on 04/01/19.	ten notification to Resident					

STATEMENT AND PLAN (	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495330	B. WING			C	
NAME OF	PROVIDER OR SUPPLIER		·Т	STREET ADDRESS, CITY, STATE, ZIP CODE	U4	/16/2019	
GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY CHESAPEAKE, VA 23323	VORTH		
(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 SHOUTH CROSS-REFERENCED TO THE APPRINCE DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 582	Continued From pa	ge 43	F 5	82			
	Social Worker on Op.m., stated, "I did r letters until January was the Social Work The Assistant Sociat to locate an ABN let have no idea what a A briefing was cond Administrator and Ir (IDON) on 04/11/19 The facility did not p about the findings.  The facility's policy t Notice with a revision Policy: It is the polic timely notices regard coverage.  Policy Explanation a included but not limited. The facility shall beneficiaries of his opayment.  -b. For Part A items a use the Skilled Facili Notice (SNF/ABN), Fef. To ensure that the	ucted via phone with the interim Director of Nursing at approximately 4:55 p.m. irresent any further information litled Advanced Beneficiary in date of 01/04/18.  By of this facility to provide ding Medicare eligibility and ind Compliance Guidelines ted to: inform Medicare or her potential liability for land services, the facility shall lity Advanced Beneficiary Form CMS-10055.					
a mys projekty (1/2) pro cham a manage,	has enough time to r not to receive the se assume financial res	nake a decision whether or rvices in question and ponsibility, the notice shall to days of the last anticipated					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495330	B. WING			04/1	)  6/2019
	PROVIDER OR SUPPLIER	DICAL CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	<del> </del>	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622 SS=E	§483.15(c) Transfer §483.15(c)(1) Facility (i) The facility must remain in the facility discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or because the reside sufficiently so the reservices provided be (C) The safety of in endangered due to status of the resident (D) The health of in otherwise be endar (E) The resident has appropriate notice, under Medicare or Nonpayment applies submit the necessary payment or after the Medicare or Medicare in Medicare or	r and discharge- ty requirements- permit each resident to y, and not transfer or ent from the facility unless- discharge is necessary for the nd the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would agered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. Is if the resident does not ary paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid;	F6	1	F622 Transfer and Discharge Requirements  1. Resident #21, #31, #22, #35 an have had their care plans upda 5-7-19. 2. All residents have the potential affected. Review of Resident transferred the facility over last 30 days we reviewed and update as indicat	ted as o  to be  out of re ed. ent be given at the in- including	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
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		495330	B. WING			04/	16/2019	
NAME UF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENE	BRIER REGIONAL ME	DICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH					
			J	C	CHESAPEAKE, VA 23323			
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PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BF	(X5) COMPLETION DATE	
F 622	Continued From pa	ge 45	F6	22				
	1	dent or other individuals in the				ļ		
	facility. The facility	must document the danger						
	that failure to transf	er or discharge would pose.						
		9		4.	Each resident who is transferred	out of		
	§483.15(c)(2) Docu	mentation.			the facility will be reviewed by the			
	When the facility tra	nsfers or discharges a of the circumstances specified			management staff by the following			
ļ	in paragraphs (c)(1)	(i)(A) through (F) of this			If any documents are found not			
1 mark	section, the facility r	must ensure that the transfer			been sent, they will be immediat			
	or discharge is docu	mented in the resident's			sent to the receiving facility.	,	j	
	communicated to th	appropriate information is e receiving health care			Results and reviews will be		-	
	institution or provide	or receiving nearin care			<u></u>		ŀ	
		the resident's medical record			incorporated into the facilities Q	API	ļ	
	must include:	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			process to ensure compliance is		ľ	
İ	(A) The basis for the	e transfer per paragraph (c)(1)			achieved and sustained.			
1	(i) of this section.	argaroph (a)(1)(i)(A) at this		l		l		
[	section the enecific	ragraph (c)(1)(i)(A) of this resident need(s) that cannot						
1	be met, facility atten	ipts to meet the resident		ļ		1		
İ	needs, and the servi	ce available at the receiving				l	1	
	facility to meet the n	eed(s).						
		on required by paragraph (c)				4		
ļ	(2)(i) of this section i	must be made by-					1	
	(A) The resident's pl	nysician when transfer or						
Ì	discharge is necessa	ary under paragraph (c) (1)				]		
	(A) or (B) of this sec	tion; and				ı		
	(B) A physician wher	transfer or discharge is						
	necessary under par	agraph (c)(1)(i)(C) or (D) of				1		
	this section. (iii) Information provi	idad to the receiving				ļ	ĺ	
-	must include a minin	ded to the receiving provider num of the following:	•			ļ		
	(A) Contact informati	ion of the practitioner		-			-	
	responsible for the c	are of the resident					Ī	
		entative information including					ļ	
	contact information							
	(C) Advance Directiv	e information		Ì				
	(D) All special instruc	ctions or precautions for		-		1		
		-				-		
							f	

NAME OF PROVIDER OR SUPPLIER  GRIEENBRIER REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, 2P CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, V. A. 2323  [ACAI DEFICIAL WAST BE REFECEDED BY PULL REGULATORY OR LISC IDENTIFYING INFORMATION)  FAREFUL ATORY OR LISC IDENTIFYING INFORMATION)  F 622  Continued From page 46 ongoing care, as appropriate.  (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with \$489.21(c)(2) as applicable, and any other documentation, as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care.  This RECUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, and clinical record review, it was determined that facility staff failed to evidence that care plan goals were sent with the resident during a facility-initiated transfer to the hospital on 1/13/19.  1. For Resident #21, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/18/19.  3. For Resident #22, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/18/19.  4. The tacility staff failed to convey to the receiving provider, Resident #35's Plan of Care Summary upon transfer to the hospital on 9/4/19.  4. The facility staff failed to convey to the receiving provider, Resident #35's Plan of Care Summary upon transfer to the hospital on 1/18/19.  5. The facility staff failed to send care plan goals upon Resident #41's discharge to the hospital on 1/18/19.		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		LE CONSTRUCTION	(X3) DAT	TE SURVEY	
STREET ADDRESS, CITY, STATE, ZIP CODE  GREENBRIER REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAYN NORTH  CHESAPFAKE, VA. 23323  PRICES PROVIDERS OF AN OF CORRECTION  (ECAN DEPOCIONY MIST BE PRECEDED BY PULL  REGULATORY OR LSC IDENTIFYING NIPORMATION)  F 622  Continued From page 46  ongoing care, as appropriate,  (E) Comprehensive care plan goals;  (F) All other necessary information, including a copy of the resident's discharge summary, consistent with \$48.82.15(c)/2 as applicable, not any other documentation, as applicable, to ensure a safe and effective transition of care.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, facility document review, and clinical record review; it was determined that facility staff failed to evidence that all the required documentation (including care plan goals) was sent with the resident during a facility-initiated transfer to the hospital for 5 of 44 residents in the survey sample, Resident #21, 31, 22, 35, 41.  1. For Resident #21, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/13/19.  2. For Resident #22, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 1/18/19.  3. For Resident #22, facility staff failed to evidence that care plan goals were sent with the resident during a transfer to the hospital on 3/4/19.  4. The facility staff failed to convey to the receiving provider, Resident #35's Plan of Care Summary upon transfer to the hospital 12/18/16.  5. The facility staff failed to send care plan goals			495330				1	=	
GREENBRIER REGIONAL MEDICAL CENTER    TOT GEORGE WASHINGTON HIGHWAY NORTH CHESAPPAKE, VA. 23323   SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FILL TAGE   TAGE   TOTAL CONTINUE   TOTAL CONTINUE   TAGE   NAME OF	PROVIDER OR SUPPLIER		L-, ,,,,,,			04/	/16/2019		
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Summary upon transfer to the hospital 12/18/18.  5. The facility staff failed to send care plan goals	1	receiving provider D	lacidant #25's Plan of Care				1	,	ĺ
5. The facility staff failed to send care plan goals		Summary upon trans	efer to the beenited 10/10/10						
5. The facility staff failed to send care plan goals upon Resident #41's discharge to the hospital on	'	ourmary upon trails	ner to trie nospital 12/18/18.				į		
upon Resident #41's discharge to the hospital on	***************************************	5. The facility staff fa	iled to send care plan goals		İ		-		ŀ
		upon Resident #41's	discharge to the hospital on				f		ĺ

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	1/18/19.  The findings include  1. For Resident #21 evidence that care president during a tra 1/13/19.  Resident #21 was an 11/3/17 and readmindiagnoses that incluing blood pressure. Resident #21's most set) assessment with an date) of 1/28/19. Resident #21's most set) assessment with an date) of 1/28/19. Resident #3/19. The following severely impaint that she had been tra 1/13/19. The following from am nurse that remesis in the shift. v 98 (pulse), 22 (resping pressure). Notified to and received New (semergency room) for Responsible party (Sof Nursing) notified to message on phone. ER (emergency room) Review of Resident #Hospital Transfer Foresident #10.	facility staff failed to plan goals were sent with the insfer to the hospital on ted on 1/21/19 with ded but were not limited to, dementia, and diabetes. It recent MDS (minimum data is a significant change ARD (assessment reference sident #21 was coded as it of in cognitive function on at for Mental Status Exam.  #21's nursing notes, revealed ansferred to the hospital on any note was written: "reported esident had episode of /s (vital signs) 102.3 (temp) rations), 146/55 (blood ong term of (physician) on call ic) order to send to ER or evaluation and treatment. For incomposition of the inco	F6	i22			
	1/13/19, failed to evid	dence that care plan goals sident upon transfer to the				P > PH + C is + C + C + C + C + C + C + C + C + C +	

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F 622			F6	622			
	conducted with ASM member) #2, the AE nursing). When ask with residents at tim ASM #2 stated that INTERACT tool for background, assess form, the residents policy, and any pertiasked if the care plaupon transfer to the the care plan goals through to the INTE ASM #2 stated that care plan goals to the 2018. ASM #2 stated document in a note resident to the hosp she did not see the #21's INTERACT fo was not documented. On 4/12/19 at 1:32 pstaff member) #1, the DON (Director of the above concerned. For Resident #31 evidence that care president during a trail/18/19.  Resident #31 was as 1/10/19 and readmit diagnoses that included. Alzheimer's Disease	, facility staff failed to lan goals were sent with the nsfer to the hospital on dmitted to the facility on					

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F 622	,		Fe	522			
	assessment was a sassessment with an date) of 2/3/19. Resseverely impaired in Staff Assessment for	MDS (minimum data set) significant change ARD (assessment reference sident #31 was coded as being a cognitive function on the or Mental Status Exam. #31's nursing notes, revealed					THE PROPERTY OF THE PROPERTY O
	that she had been to 1/18/19. The following signs) 99.7, 64 (pulse (blood pressure) Re vomiting this eve (even) (nurse practitioner)	ransferred to the hospital on ng note was written: "v/s (vital se), 16 (respirations), 103/66 sident had 2 episodes of vening) shift. On call NP called and a new order was					
	mouth) q (every) six nausea and vomittin (2) labs to draw CBC CMP (complete met ans (sic) lipase (6) le (by mouth) abt (antit reactions noted. KU	4 mg (milligrams) po (by hours prn (as needed) for ag, STAT (immediate) *KUB (Complete blood count) (3), abolic panel) (4), amylase (5) evels. Cont (continue) on PO piotics) with no adverse B done this shift, awaiting the KUB results documented Paralytic ileus (6)."	•	e de france de la communicación de la communicación de la communicación de la communicación de la communicación			
				***************************************			
	Hospital Transfer Fo 1/13/19, failed to evid	#31's Nursing Home to rm (INTERACT) dated dence that care plan goals esident upon transfer to the					
	conducted with ASM	a.M., an interview was (administrative staff ON (assistant director of					

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

Event ID: EQPC11

Facility ID: VA0043

If continuation sheet Page 50 of 147

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	nursing). When ask with residents at tim ASM #2 stated that INTERACT tool for background, assess form, the residents policy, and any pert asked if the care plaupon transfer to the the care plan goals through to the INTE ASM #2 stated that care plan goals to the 2018. ASM #2 stated document in a note resident to the hosp she did not see the #31's INTERACT fo was not documented was not documented to 4/12/19 at 1:32 p staff member) #1, the DON (Director of the above concern (1) Zofran is indicate nausea and vomiting obtained from The N https://dailymed.nlm.m?setid=555f81bc-40.  (2) KUB (Kidneys, Uiexamination of abdo about the kidneys, uiinformation was obtainstitutes of Health. https://www.ncbi.nlm (3) CBC -Your blood	need what paperwork was sent the of a transfer to the hospital, nurses will fill out and send an m, an SBAR (situation, sment, recommendation) history and physical, bed hold inent labs, orders etc. When an was sent with the resident hospital, ASM #2 stated that should be able to be pulled RACT form electronically. nursing started pulling the period of the nurses do not what items were sent with the ital. ASM #2 confirmed that care plan goals on Resident m. ASM #2 stated that if it did then it was not done.  D.m., ASM (administrative readministrator and ASM #4, if Nursing) were made aware ins.  and for the prevention of the prevention	F6	22			

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F 622	Continued From para Blood count tests more cells in your blood your overall health. diagnose diseases anemia, infections, cancers, and immuninformation was obtinstitutes of Health. https://www.ncbi.nlm (4) CMP-A group of several parameters, (glucose), proteins, and potassium), waurea nitrogen [BUN] enzymes. The comp (CMP) is used to as diagnose and guide diseases. This informational Institut https://aidsinfo.nih.gsary/2992/compref (5) Amyalse and Lippancreatitis requires of the three diagnos abdominal pain, elevitipase, and radiologi This information was institutes of Health. https://www.ncbi.nlm 53980/. (6) Mild Paralytic ileumuscles of the intes	ge 51 neasure the number and types d. This helps doctors check on The tests can also help to and conditions such as clotting problems, blood ne system disorders. This ained from The National m.nih.gov/pubmed/3537252. blood tests that measures , including blood sugar electrolytes (such as sodium ste products (such as blood l and creatinine), and prehensive metabolic panel sess overall health and to treatment of numerous mation was obtained from	F 6	DEFICIENCY)			
	Paralytic ileus may to inflammation, and cowas obtained from Thealth.	pe caused by surgery, ertain drugs. This information The National Institutes of gov/publications/dictionaries/c				3. 11. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1	-

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	evidence that care p	, facility staff failed to plan goals were sent with the ansfer to the hospital on						
	1/13/17 and readmit that included but we disorder, severe par weakness, Hepatitis malnutrition and dial #22's most recent Wassessment was a CARD (assessment re Resident #22 was compaired in cognitive	dmitted to the facility on ted on 3/6/19 with diagnoses are not limited to, anxiety nic disorder, muscle a C, protein-calorie betes (type two). Resident IDS (minimum data set) quarterly assessment with an eference date of 1/31/19. Toded as being moderately a function scoring 11 out of 15 interview for Mental Status)						
de de la manuel partir de la constanta de la c	that she had been tr 3/4/19. The following (Laboratory) results care-physician) rega	#22's nursing notes, revealed ansferred to the hospital on g was documented: "Labs call in to LTC (long term arding Glucose (sugar) Critical se (Name of On call nurse) ag call back."		d de une vez e con un manuel de misque de demonstrata para estado per prepieto de destado de la de-				
İ		3/4/19 documented the sident to ER for evaluation of evel."		Part of the Part o		e en en en en en en en en en en en en en		
	Hospital Transfer Fo. 3/4/19, failed to evide were sent with the re hospital.	#22's Nursing Home to rm (INTERACT) dated ence that care plan goals sident upon transfer to the				A CASE A CASE OF THE THE PROPERTY OF THE PROPE		
	On 4/12/19 at 9:57 A	.M., an interview was						

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GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	;
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	were severely impa In section "G" (Physical was coded as required one with bed mobilitransfers, total care dressing, personal land Peview of the discharged-return note to the clinical of the discharged-return note dated 12/18/18 Resident #35 was a deep sleep and abnadministered for temphysician was made condition/abnormal treatment was admitted again. The parameter the resident hospital for evaluation was possible to the above findings of Administrator, Directions was required to the conditions of the above findings of Administrator, Directions was required to the conditions of the above findings of Administrator, Directions on the conditions of the co	sical functioning) the resident ring extensive assistance of ty, total care of two with of one with eating, locomotion nygiene, toileting and bathing.  arge MDS assessment dated Resident #35 was of anticipated.  al record revealed a nurse's ty, at 7:55 p.m., which stated ssessed at 5:35 p.m., in a formal vital signs. Tylenol was apperature and the on-call enaware of the resident's vital signs. A nebulizer instered for wheezing and the erefore the physician was only sician gave an order to the local acute care on and treatment.  I was included which stated the dot the receiving providers that it is any of the comprehensive the time of discharge or as the actual time of transfer.	F6	622			
	Corporate Consultar approximately 1:40 p no additional informations. The facility staff f	nt on 4/16/19 at o.m. The facility staff provided				A yet deren e e alema a de la composition de la constitución de la con	Tree months and the second sec

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY
		495330					С
HAVEOE	NDOVENED OD OVERDIEM	49000	B. WING			04/	16/2019
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	BE	(XS) COMPLETION DATE
F 622	Continued From page	ge 55	Fe	22		, , ,	
!	facility originally on 1/22/19 with diagno to Dysphagia (diffici	84 year old admitted to the 4/6/15 and readmitted on ses to include but not limited ulty swallowing), Major r, Type 2 Diabetes Mellitus					
	assessment was a S Assessment Refere The Brief Interview t a 4 out of a possible has severe cognitive	nimum Data Set (MDS) Significant Change with an nce Date (ARD) of 1/29/19. for Mental Status (BIMS) was a 15, indicating Resident #41 is impairment. Resident #41's was also reviewed and is as follows:					
TO COLOR DE LA COL	Anticipated Assessn	ital Discharge Return nent with ARD of 1/18/19. sessment with ARD of					
	Resident #41's Prog and are documented	ress Notes were reviewed d in part, as follows:					
Comprehensia	amounts of beige co	esident vomiting large blored phlegm, emesis X3, nds right side upper lobes, esident transported via 911 to :30 am.				The second secon	
	1/18/19 14:37 (2:37) Name (hospital) with	PM: resident admitted to diagnosis of Hypoxia.				Application of the second of t	
	Resident #41's Care on 3/19/19 were revi part, as follows:	Plan that were last revised ewed and are documented in					i Constitution
	Potential for alteration	n in dietary intake related to					1

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		E SURVEY IPLETED	
		495330	B. WING		į.	С	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/	16/2019	
GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	ASHINGTON HIGHWAY NORTH		
(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 X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 623 SS=E	poor appetite with has ar self care performan hemiplegia. The resident has a langry). The resident uses so the resident has did the resident has did the resident has part of the resident has part	istory of weight loss.  ADL (activities of daily living) ce deficit with history of behavior problem (getting nuff. pertension. abetes mellitus. sk for falls. in related to arthritis.  eximately 1:30 P.M. the f Nursing (ADON) was asked are Plan Goals had been sent on discharge to the hospital ON stated, "No we have not are plan goals with the harge to the hospital."  cility was unable to provide a Goals to be sent upon spital for their residents.  P.M. a pre-exit debriefing was strator, the Director of operations mation was shared.  er information was shared.  se Before Transfer/Discharge ()-(6)(8)	F 62				
-	resident, the facility (i) Notify the resident representative(s) of						

F 623 Continued From page 57 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.  (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section, and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharge.  (ii) Notice must be made as soon as practicable before transfer or discharge under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; (E) A resident has not resided in the facility for 30		ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
GREENBRIER REGIONAL MEDICAL CENTER  C(24) DISLIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 623 Continued From page 57 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudisman.  (ii) Record the reasons for the transfer or discharge in the reasons for the notice the items described in paragraph (c)(5) of this section, and (iii) Include in the notice the items described in paragraph (c)(6) of this section, and (c)(8) of this section, the notice of transfer or discharge required under this section in paragraph (c)(1) (iii) (			495330	B. WING			1	
F 623  Continued From page 57 the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.  (ii) Record the reasons for the transfer or discharge in the resident's medical record in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice.  (i) Except as specified in paragraphs (c)(4)(ii) and (c)(ii) Of this section the resident is transfer or discharge required under this section must be made by the facility at least 30 days before the resident is reached before transfer or discharge when-(A) The safety of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;  (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;  (C) The resident's discharged in paragraph (c)(1)(i)(D) of this section;  (D) An immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;  (E) A resident has not resided in the facility for 30 the section that a property is a property is a property in the date of discharge on the facility of 30 the section that the section of the resident's discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(i)(i) of this section;  (E) A resident has not resided in the facility for 30 the section that a company is a constant to the original constant in the section of the resident is urgent medical needs, under paragraph (c)(1)(i)(i)(i) of this section;  (E) A resident has not resided in the facility for 30 the section of the resident is transfer to discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(ii)(ii) of this section;  (E) A resident has not resided in the facility for 30 the section of the resident's under the section of the resident is under the section of the resident is the section of the resident is the section of the resident is the section of the resident is the sectio			DICAL CENTER		11	017 GEORGE WASHINGTON HIGHWAY NOF		
the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.  (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section, and  (iii) Include in the notice the items described in paragraph (c)(5) of this section.  §483.15(c)(4) Timing of the notice.  (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.  (ii) Notice must be made as soon as practicable before transfer or discharge when-(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;  (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;  (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;  (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section;  (E) A resident has not resided in the facility for 30	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
\$483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:  be maintained in the Social Worker's office. Management staff will be inserviced on the process.	F 623	the reasons for the language and manr facility must send a representative of th Long-Term Care Or (ii) Record the reas discharge in the resaccordance with pa and (iii) Include in the ne paragraph (c)(5) of §483.15(c)(4) Timin (i) Except as specific) (c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be referred transfer or d (A) The safety of ince the endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's hallow a more immedunder paragraph (c) (D) An immediate to required by the resident paragraph (c) (E) A resident has redays.	move in writing and in a ner they understand. The copy of the notice to a e Office of the State mbudsman. ons for the transfer or sident's medical record in ragraph (c)(2) of this section; otice the items described in this section.  In this section.  In the notice of transfer or under this section must be at least 30 days before the ed or discharged. In the facility would der paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of dividuals in the facility would der paragraph (c)(1)(i)(D) of mealth improves sufficiently to diate transfer or discharge is dent's urgent medical needs, of (1)(i)(A) of this section; or not resided in the facility for 30 eents of the notice. The written paragraph (c)(3) of this section	F	323	I. The Ombudsman will be notified the resident's discharges for Resiler #21 who discharged on 1-31-19, Resident #31 who discharged on 19, Resident #22 who discharged 4-19, Resident #35 who discharged 12-18-18, Resident #41 who discharged on 1-18-19, Resident #17 who discharged on 4-8-19, Resident # who discharged on 8-19-18, and Resident #103 who discharged on 24-18.  2. All residents have the potential affected.  3. At the end of each month a list resident discharges with the date discharge will be faxed to the Off the State Long-Term Care Ombud by the Social worker or a person designated by the Administrator her absents. A record of these list be maintained in the Social Work office. Management staff will be in the Social work office.	ed of ident  1-18- on 3- ed on harged  57 n 11- I to be of ice of ice of ice of ice will er's	-

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT COM	E SURVEY MPLETED
		495330	B, WING		· · · · · · · · · · · · · · · · · · ·		С
NAMEOG	PROVIDER OR SUPPLIER	493330	B, WING			04/	/16/2019
NAME OF	LUCAIDER ON SUPPLIER		-		TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL MEI	DICAL CENTER			017 GEORGE WASHINGTON HIGHWAY NO	RTH	
				CHESAPEAKE, VA 23323			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10		PROVIDER'S PLAN OF CORRECTION	1	7/25
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR LS	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From pag	ge 58	F 62	23			
	(i) The reason for to	ransfer or discharge;	,	-	•		
•	(ii) The effective date of transfer or discharge;			1	A The Administrator - util 1 to		
	(iii) The location to v	which the resident is			4. The Administrator or his design		1
	transferred or discharged; (iv) A statement of the resident's appeal rights,				check the binder each month to e	nsure	
					all discharges were reported. Resu	ılts of	
	including the name,	address (mailing and email), per of the entity which			all reviews and audits will be		
	receives such reque	ests; and information on how			incorporated into the Center's QA	enter's QAPI	
	to obtain an appeal	form and assistance in			process to ensure compliance is		
	completing the form	and submitting the appeal			achieved and sustained.	-	
	hearing request;			,	acineved and sustained.	į	
	(v) The name, addre	ess (mailing and email) and					
	telephone number o	f the Office of the State					
	Long-Term Care On						
	(vi) For nursing facili	ity residents with intellectual					
	and developmental disabilities, the mails	ng and email address and					
	telephone number of	f the agency responsible for				1	-
	the protection and a	dvocacy of individuals with				1	
	developmental disab	pilities established under Part				Ī	
	C of the Developmen	ntal Disabilities Assistance					Ī
l	and Bill of Rights Act	t of 2000 (Pub. L. 106-402,		ı			
Ì	codified at 42 U.S.C.	. 15001 et seq.); and				l	Ī
-	(vii) For nursing facil	ity residents with a mental				-	
	disorder or related di	isabilities, the mailing and		ĺ		1	
	email address and te	elephone number of the					
	agency responsible f	for the protection and					
	advocacy of individua	als with a mental disorder					ł
	established under the	e Protection and Advocacy					
	for Mentally III Individ	luals Act.					
	§483.15(c)(6) Chang	es to the notice		7			
	If the information in t	he notice changes prior to				İ	
}	effecting the transfer	or discharge, the facility					
-	must update the reci	pients of the notice as soon					
	as practicable once t	he updated information		-		ļ	
	becomes available.	e de la companya de l				-	
4		Plane a tra		1		alaa laa	İ

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	t .		CONSTRUCTION		E SURVEY MPLETED
		495330	B. WING	<del></del>			C <b>/16/2019</b>
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	DICAL CENTER		101	REET ADDRESS, CITY, STATE, ZIP CODE 7 GEORGE WASHINGTON HIGHWAY NO ESAPEAKE, VA 23323		10/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	§483.15(c)(8) Notice In the case of facility the administrator of written notification p to the State Survey State Long-Term Cathe facility, and the well as the plan for relocation of the res 483.70(l). This REQUIREMEN by: Based on staff interreview, and clinical indetermined that facility written documentation the survey sample 41, 17, 57, and 103.  1. For Resident #21, written documentation Long-Term Care On transfer to the hospit 2. For Resident #31, written documentation Long-Term Care On transfer to the hospit 3. For Resident #22, written documentation Long-Term Care On transfer to the hospit 4. The facility staff fastate Long-Term Care On transfer to the hospit 4. The facility staff fastate Long-Term Care	e in advance of facility closure y closure, the individual who is the facility must provide prior to the impending closure Agency, the Office of the are Ombudsman, residents of resident representatives, as the transfer and adequate idents, as required at §  IT is not met as evidenced eview, facility document record review, it was lity staff failed to provide on that the ombudsman was a transfer for 8 of 44 residents e, Resident #21, #31, #22, 35, facility staff failed to provide on that the Office of the State abudsman was notified of his tal on 1/18/19.  facility staff failed to provide on that the Office of the State abudsman was notified of his tal on 1/18/19.	F 6	3			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	:		PLE CONSTRUCTION		E SURVEY MPLETED
	:	495330	B. WING				
NAME OF	PROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	16/2019
COEENE	DIED DECIONAL AND	DIGAL OCUTED	Ì	1	1017 GEORGE WASHINGTON HIGHWAY NO	RTH	
GNEEN	BRIER REGIONAL ME	DICAL CENTER			CHESAPEAKE, VA 23323		
(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 APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
F 623	Continued From pa	ge 60	Fe	323	3		
	State Long-Term Ca	ailed to notify the Office of the are Ombudsman of Resident he hospital on 1/18/19.	,				
	discharge and send	ailed to provide a notice of a copy to the Office of the are Ombudsman for					
	with a hospital notic	failed to provide Resident #17 e of discharge and send a i the State Long-Term Care					
	#103 with a hospital	ailed to provide Resident notice of discharge and send of the State Long-Term Care					
to produce de la companya de la comp	The findings include						
	11/3/17 and readmidiagnoses that incluhigh blood pressure. Resident #21's most set) assessment with an date) of 1/28/19. Rebeing severely impathe Staff Assessment	ded but were not limited to dementia, and diabetes. It recent MDS (minimum data is a significant change ARD (assessment reference sident #21 was coded as fired in cognitive function on the for Mental Status Exam.					
	that she had been tr. 1/13/19. The followir from am nurse that r	#21's nursing notes, revealed ansferred to the hospital on ang note was written: "reported esident had episode of this (vital signs) 102.3 (temp)				And the second s	

STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495330	B. WING			ı	С
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04/	16/2019
	BRIER REGIONAL ME	DICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		RTH		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From page	ge 61	F6	323			
	98 (pulse), 22 (resp pressure). Notified I and received New (semergency room) f Responsible party (sof Nursing) notified message on phone. ER (emergency room) There was no further record that the ombit this transfer.  On 4/12/19 at 11:20 conducted with OSM social worker assists had no role when a subspital. OSM #2 states the social worker has hospital transfers in the social worker has 2019 and was no lor stated that she was ombudsman for hospital fransfers in the DOM (Director of the above concerning the social worker has 1:32 pstaff member) #1, the DOM (Director of the above concerning the social worker of the above concerning the social worker has 2019 and was no lor stated that she was ombudsman for hospital transfers in the social worker has 2019 and was no lor stated that she was ombudsman for hospital transfers in the social worker has 2019 and was no lor stated that she was ombudsman for hospital transfers in the social worker has 2019 and was no lor stated that she was ombudsman for hospital transfers in the social worker has 2019 and was no lor stated that she was ombudsman for hospital transfers in the social worker has 2019 and was no lor stated that she was ombudsman for hospital transfers in the social worker has 2019 and was no lor stated that she was ombudsman for hospital transfers in the social worker has 2019 and	irations), 146/55 (blood ong term of Virginia on call sic) order to send to ER for evaluation and treatment. Son) notified, DON (Director by this nurse leaving Report called into (Name of m)."  It evidence in the clinical udsman was made aware of a.m., an interview was for the complete of the complete	F 6	623			
	written documentation	facility staff failed to provide on that the ombudsman was er to the hospital on 1/18/19.					
	that she had been tra 1/18/19. The followin signs) 99.7, 64 (puls	#31's nursing notes, revealed ansferred to the hospital on ig note was written: "v/s (vital e), 16 (respirations), 103/66 sident had 2 episodes of				Medical delications and appropriate property of the control of the	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495330	B. WING	<b>}</b>		l	C
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	*		STREET ADDRESS, CITY, STATE, ZIP 1017 GEORGE WASHINGTON HIG CHESAPEAKE, VA 23323			/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
	(nurse practitioner) given for Zofran 4 r q (every) six hours p and vomiting, STAT ureters, bladder) lal blood count), CMP (amylase ans (sic) lip on PO (by mouth) al adverse reactions no awaiting results." Reureter bladder) resulting in the next note dated following: "Resident room) for evaluation (responsible party) at There was no further record that the ombut this transfer.  On 4/12/19 at 11:20 conducted with OSM social worker assiste had no role when a rhospital. OSM #2 stathe social worker had hospital transfers in the social worker had 2019 and was no lon	vening) shift. On call NP called and a new order was ng (milligrams) po (by mouth) orn (as needed) for nausea (immediate) KUB (kidney, os to draw CBC (complete complete metabolic panel), oase levels. Cont (continue) of (antibiotics) with no oted. KUB done this shift, eview of the KUB (kidney lts documented the following:  1/18/19 documented the sent to ER (emergency to KUB results. RP tware."  The evidence in the clinical addsman was made aware of a.m., an interview was a (other staff member) #2, the exited that she was not sure of a notified the ombudsman for the past. OSM #2 stated that at left the facility in January of ger employed. OSM #2 never told to notify the	F6	523			
1	staff member) #1, the	m., ASM (administrative e administrator and ASM #?, Nursing) were made aware s.					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		) MULTIPLE CONSTRUCTION SUILDING		(X3) DATE SURVEY COMPLETED	
		495330	B. WING			l .	C
NAME OF	PROVIDER OR SUPPLIER		<del>'</del> -	STR	EET ADDRESS, CITY, STATE, ZIP CODE	U4/	/16/2019
ODEEN			-		7 GEORGE WASHINGTON HIGHWAY NO	<b>DTH</b>	
GHEENE	BRIER REGIONAL ME	DICAL CENTER			ESAPEAKE, VA 23323	11111	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	iD		PROVIDER'S PLAN OF CORRECTION	d	Ores
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	Continued From pa	ge 63	F6	23			
	written documentati notified for his trans	2, facility staff failed to provide ion that the ombudsman was sfer to the hospital on 3/4/19.					
	1/13/17 and readmithat included but we disorder, severe paweakness, Hepatitis malnutrition and dia	tted on 3/6/19 with diagnoses ere not limited to anxiety nic disorder, muscle s C, protein-calorie betes (type two). Resident					
TO THE STATE OF TH	assessment was a c ARD (assessment r Resident #22 was c impaired in cognitive	MDS (minimum data set) quarterly assessment with an eference date of 1/31/19. oded as being moderately e function scoring 11 out of 15 nterview for Mental Status)					
	that she had been tr 3/4/19. The following (Laboratory) results care-physician) rega	#22's nursing notes, revealed ransferred to the hospital on g was documented: "Labs call in to LTC (long term arding Glucose (sugar) Critical se (Name of On call nurse) ng call back."		. And the state of		The second state of the se	
	The next note dated following: "Send Res Critical lab/glucose I	3/4/19 documented the sident to ER for evaluation of evel."		Mary desired the color and construction by the color			
	There was no furthe record that the ombuthis transfer.	r evidence in the clinical udsman was made aware of					
i	conducted with OSN	a.m., an interview was 1 (other staff member) #2, the ant. OSM #2 stated that she				and the second s	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	BRIER REGIONAL ME	DICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
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	had no role when a hospital. OSM #2 st the social worker ha hospital transfers in the social worker ha 2019 and was no lostated that she was ombudsman for hos On 4/12/19 at 1:32 pstaff member) #1, the DON (Director of the above concers) 4. Resident #35 was facility 10/4/15, and 12/31/18, after an accurrent diagnoses in hemiparesis, GERD The quarterly Minimassessment with an (ARD) of 2/7/19, cocompleting the Brief (BIMS) and scoring Resident #35's daily were severely impair in section "G" (Physical was coded as requir one with bed mobility transfers, total care of dressing, personal hereturn not anticipated.	resident was sent to the ated that she was not sure of ad notified the ombudsman for the past. OSM #2 stated that ad left the facility in January of nger employed. OSM #2 never told to notify the spital transfers.  D.m., ASM (administrative ne administrator and ASM #4, of Nursing) were made aware ns.  soriginally admitted to the was readmitted to the facility cute care hospital stay. The neluded; diabetes, and Alzheimer's disease.  The neluded; diabetes, and Alzheimer's disease.  The neluded the resident as assessment reference date ded the resident as assessment reference date decision making abilities red.  The neluded to the facility cute care for Mental Status 2 out of 15. This indicated decision making abilities red.  The neluded to the facility cute care of two with of one with eating, locomotion ygiene, toileting and bathing.  The negative session to the facility of one with eating, locomotion ygiene, toileting and bathing.	F6	323			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION			E SURVEY
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F 623	note dated 12/18/18 Resident #35 was a deep sleep and abr administered for ter physician was made condition/abnormal treatment was admi wasn't successful th notified again. The transfer the residen hospital for evaluati  An interview was co Worker Assistant 4/ p.m. The Social Worker notified the O the hospital but it co of the Social Worke instructed to do so.  The above findings Administrator, Direct Corporate Consultar approximately 1:40 stated at the time of transfer the facility s requirement to notify Ombudsman but in she had in-serviced requirements using 5. Resident #41 wa the facility originally 1/22/19 with diagnos to *Dysphagia (diffic Depressive Disorder and *Dementia.	assessed at 5:35 p.m., in a a normal vital signs. Tylenol was apperature and the on-call e aware of the resident's vital signs. A nebulizer inistered for wheezing and nerefore the physician was physician gave an order to to the local acute care on and treatment.  Inducted with the Social 11/19, at approximately 3:49 orker Assistant stated she had imbudsman of discharges to buld have been a responsibility in Director but she wasn't were shared with the tor of Nursing and the not of 1/16/19 at p.m., the Director of Nursing Resident 35's hospital staff was not aware of the ty the Long-Term Care late February or early March the facility's staff of the withey would meet the	F6	523			

STATEMENT AND PLAN (	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LTIPLE CONSTRUCTION DING			E SURVEY
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GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHW. CHESAPEAKE, VA 23323	IY NOR	RTH	
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	assessment was a Assessment Refere The Brief Interview a 4 out of a possible has severe cognitiv MDS submit history documented in part 1. Unplanned Hosp Anticipated Assessr 2. Facility Entry Ass 1/22/19.  Resident #41's Progand are documented in a documented in part 1/18/19 4:31 AM: reamounts of beige codiminished lung sounasal congestion. In Name (hospital) at 4/18/19 14:37 (2:37) Name (hospital) with On 4/15/19 at approinterview was conducted worker regarding or resident discharges. Worker stated, "I diction for her when she (Richard Interview Control of the middle of Jane) and the middle of Jane) and the middle of Jane) are sident discharges.	Significant Change with an ence Date (ARD) of 1/29/19. for Mental Status (BIMS) was a 15, indicating Resident #41 e impairment. Resident #41's was also reviewed and is, as follows:  Dital Discharge Returnment with ARD of 1/18/19. Sessment with ARD of understand with ARD of control of the part, as follows:  Discharge Returnment with ARD of control of the part, as follows:  Discharge Returnment with ARD of control of the part, as follows:  Discharge Returnment with ARD of control of the part, as follows:  Discharge Returnment with ARD of control of the part, as follows:  Discharge Returnment with ARD of control of the part, as follows:	F 6	523			
1	The facility policy titl Notice" last revised of is documented in pa	ed "Transfer or Discharge on 12/2016 was reviewed and rt, as follows:					

PRINTED: 05/23/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	ZIP CODE HIGHWAY NORTH DE CORRECTION CTION SHOULD BE OTHE APPROPRIATE	
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	PROVIDER OR SUPPLIER  REGIONAL ME	DICAL CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		/16/2019
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F 623	Continued From pa		Fθ	523			
	the State Long-Terr	tice will be sent to the Office of n Care Ombudsman. P.M. a pre-exit debriefing was					
The second secon	held with the Admin Nursing and the Re were the above info	istrator, the Director of gional Director of Operations rmation was shared.					And the state of t
an to see of the second	Prior to exit no furth by facility staff.	er information was presented					
PROPERTY AND AND AND AND AND AND AND AND AND AND	1/28/19 with diagnos of sepsis due to Esc esophagitis, muscle abnormalities of gai depression, diabetes hyperlipidemia, and facility staff failed to	s re-admitted to the facility on ses which included a history cherichia coli (E.Coli) weakness, dysphagia, I, hypertension, COPD, s, cardiovascular disease, contractures of left hand. The provide Resident #57 with a and send a copy to the office		ada i naman menjipiyaja Mitsian libida irr canda maayay qibasa da maa maq jiriyiyi iyr wa ma			
	2/25/19 assessed the difficulties in the area or understanding an In the area of Cognitassessed for a brief (BIMS) and scored assessed in the area (ADL'S) as requiring	Data Set (MDS) dated is resident as having no a of hearing, speech, vision d the ability to be understood. Live Patterns this resident was Interview for mental Status a (13). This resident was a of Activities of Daily Living supervision and one person		-poplitigiskunda vana a maya tepississististiska tilisasi a manga majapunganda ka			
7.77	locomotion on unit. T as requiring extensiv set-up in the area of hygiene. In the area resident was assess	bed mobility, transfers, and This resident was assessed to assistance with one person dressing and personal of Pain Management this ed as having pain within the dent was assessed as				e de la destable traba en comme per applicações de comme de la comme de la comme de la comme de la comme de la	

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

Event ID: EQPC11

Facility ID: VA0043

If continuation sheet Page 68 of 147

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	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	(3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		ST 10	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO HESAPEAKE, VA 23323		/16/2019	
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F 623	as having pain which night. In the area of rated pain in the las from 0 to 10.  A Nursing note date	ge 68  n. This resident was assessed h made it difficult to sleep at Pain Intensity this resident t 5 days as a (10) on a scale d 8/19/18 at 18:44 (6:44 P.M.) laining of groin pain. Pt is in	F€	623				
The second secon	tears. Pt. stated that all week but pt has to does have Foley that urine. Foley was flus with increased pain has been down to direquested to be sendon't that he will. Pt	the pain has been off and on ailed to report the pain. Pt at is patent and flowing yellow shed with NS (normal saline) noted by pt. Pt stated that he ecrease pain with no relief. Pt t out to ER for eval an if I is self responsible, on call NP notified. Resident transported		mprinsississississis delikasis imm mynymynyn (1947-1951) falamat ingymysississississississississississississis				
	4/11/19 at 2:55 P.M. was not provided wit was a copy sent to to The facility staff to p	rovide Resident #57 with a		Medicinal tylem are are are are are are are are are are				
	the office of the Oml 7. Resident #17 was 1/15/18 with diagnos cardiovascular disea dementia. The facilit Resident #17 with a and send a copy to t  An Annual MDS date resident as having no difficulty. Resident #	admitted to the facility on		THE PROPERTY OF THE RESEARCH OF THE PROPERTY O				

MAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, 2IP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHEAPPEAKE, VA 23323  FREETY TAG  SUMMARY STATEMENT OF DEFICIENCES TAG  SUMMARY STATEMENT OF DEFICIENCES TAG  SUMMARY STATEMENT OF DEFICIENCES TAG  SUMMARY STATEMENT OF DEFICIENCES TAG  SUMMARY STATEMENT OF DEFICIENCES TAG  FREDULATORY OR LSC IDENTIFYING INFORMATION)  FREDULATORY OR LSC IDENTIFYING INFORMATION  FREDULATORY OR LSC IDENTIFYING INFORMATION  FREDULATORY OR LSC IDENTIFYING INFORMATION  FREDULATORY OR LSC IDENTIFYING INFORMATION  A Nursing Note dated 4/8/19 at 22:45 (10:45 P.M.) Indicated: "CNA (certified rursing assistant) came and got this nurse to go into the residents room because something was wrong. When walking into the residents room the resident was sitting up in the chair slummed over with vomit all over her chest and her mouth was over to the side and her eyes were open. This nurse kept calling out the residents room the resident side of the resident in the side and her eyes were open. This nurse kept calling out the residents name the resident side of the resident on her with HOB elevated to about 56 degrees. CNA got vitals within normal range the residents on her with HOB elevated to about 56 degrees. CNA got vitals within normal range the residents skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident, 911 was called, All responsible parties were called and notified."  During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #17 was not provided with a notice of discharge nor was a copy sent to the Ombudsman.  The facility staff failed to provide Resident #17 with a hospital notice of discharge and send a copy to the office of the Ombudsman.  8. Resident #103 was admitted to the facility on 4/28/13 with diagnoses of hypertension, diabetes mellitus, dysphagia, cardiovascular tacking in the provide Resident #103 with a		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
MAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  CALID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  FREGULATORY OR LSC IDENTIFYING INFORMATION)  FOR THE PROVIDER OF THE APPROPRIATE OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 623  Continued From page 69  resident was assessed as having a BIMS score of 15 which indicated no cognitive impairment.  A Nursing Note dated 4/8/19 at 22:45 (10:45 P.M.) indicated: "CNA (certified nursing assistant) came and got this nurse to go into the residents room because something was wrong. When walking into the residents room because something was wrong. When walking into the residents room because something was wrong. When walking into the residents room because something was wrong. When walking into the residents are the resident did not respond but just looked at this nurse but did not respond to her name, she just looked and moved around. We then repositioned the resident sill did not respond to her name, she just looked and moved around. We then repositioned the resident sill did not respond to her name, she just looked and moved around. We then repositioned the resident skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident skin was cold and clammy, blood sugar was checked read at 186. Supervisor was provided with a n			495330				•		
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FREENT TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 623  Continued From page 69 resident was assessed as having a BIMS score of 15 which indicated no cognitive impairment.  A Nursing Note dated 4/8/19 at 22:45 (10:45 P.M.) indicated: "CNA (certified nursing assistant) came and got this nurse to go into the residents room because something was wrong. When walking into the residents room the resident was sitting up in the chair slummed over with vomit all over her chest and her mouth was over to the side and her eyes were open. This nurse kept calling out the residents name the resident still did not respond but just looked at this nurse but did not respond but just looked at this nurse but did not respond to the rame, she just looked and moved around. We then repositioned the resident still did not respond to the residents name the resident still did not respond to the range the residents skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident #17 was not provided with a notice of discharge nor was a copy sent to the Ombudsman.  The facility staff failed to provide Resident #17 with a hospital notice of discharge and send a copy to the office of the Ombudsman.  8. Resident #103 was admitted to the facility on 4/26/18 with diagnoses of hypertension, diabetes mellitus, dysphagia, cardiovascular accident, neuropathy, and over active bladder. The facility on 4/26/18 with diagnoses of hypertension, diabetes mellitus, dysphagia, cardiovascular accident, neuropathy, and over active bladder. The facility on 4/26/18 with diagnoses of hypertension, diabetes mellitus, dysphagia, cardiovascular accident, neuropathy, and over active bladder. The facility			DICAL CENTER		1017 GEORGE WASHINGTON HIGHW		RTH		
resident was assessed as having a BIMS score of 15 which indicated no cognitive impairment.  A Nursing Note dated 4/8/19 at 22:45 (10:45 P.M.) indicated: "CNA (certified nursing assistant) came and got this nurse to go into the residents room because something was wrong. When walking into the residents room the resident was sitting up in the chair slummed over with vomit all over her chest and her mouth was over to the side and her eyes were open. This nurse kept calling out the residents name the resident did not respond but just looked at this nurse but idd not say anything. Got nurse from the unit to help. When calling the residents name the resident still did not respond to her name, she just looked and moved around. We then repositioned the resident son her with HOB elevated to about 65 degrees. CNA got vitals within normal range the residents skin was cold and clammy, blood sugar was checked read at 186. Supervisor was brought to the room to see the condition of the resident. 911 was called. All responsible parties were called and notified."  During an interview with the social worker on 4/11/19 at 2:55 P.M. she stated, Resident #17 was not provided with a notice of discharge nor was a copy sent to the Ombudsman.  The facility staff failed to provide Resident #17 with a hospital notice of discharge and send a copy to the office of the Ombudsman.  8. Resident #103 was admitted to the facility on 4/26/18 with diagnoses of hypertension, diabetes mellitus, dysphagia, cardiovascular accident, neuropathy, and over active bladder. The facility	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF			X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			
: 31GH (CHGH O LIHINNI P DESCRIPIT # 115 MID) 9		resident was assess 15 which indicated in A Nursing Note date P.M.) indicated: "Charme and got this in room because some walking into the resisiting up in the charmover her chest and is side and her eyes we calling out the residence produced and the residence produced and the residence produced and the residence produced and the residence produced around. We on her with HOB elector of the was cold and concluded and the room to see the was called. All respond and notified."  During an interview 4/11/19 at 2:55 P.M. was not provided with was a copy sent to the facility staff failed with a hospital notice copy to the office of 8. Resident #103 was 4/26/18 with diagnosmellitus, dysphagia, neuropathy, and over	sed as having a BIMS score of no cognitive impairment.  and 4/8/19 at 22:45 (10:45  NA (certified nursing assistant) increated to go into the residents ething was wrong. When idents room the resident was ir slummed over with vomit all her mouth was over to the vere open. This nurse kept ents name the resident did not ked at this nurse but did not was from the unit to help. Is sidents name the resident still the roame, she just looked and then repositioned the resident evated to about 65 degrees. In normal range the residents clammy, blood sugar was so an anormal range the resident still the roame. Supervisor was brought to condition of the resident. 911 consible parties were called with the social worker on she stated, Resident #17 the a notice of discharge nor the Ombudsman.  The dot oprovide Resident #17 the of discharge and send a the Ombudsman.  The sadmitted to the facility on see of hypertension, diabetes cardiovascular accident, or active bladder. The facility	F 6	523				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	}	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED		
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				CHESAPEAKE, VA 23323			
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SS=E	hospital notice of dithe office of the Ome A 2/20/19 MDS assisted of Cognitive Status BIMS assessment with A Nursing Note date P.M.) indicated: "Responsible to the Normal of the Nursing Note date P.M.) indicated: "Responsible to the Normal of Nursing During an interview 4/11/19 at 2:55 P.M. was not provided with was a copy sent to the transport of Notice of Bed Hold In CFR(s): 483.15(d) Notice of S483.15(d) Notice of Notice of Notice of Notice of Notice of Notice of	scharge and send a copy to budsman.  essed this resident in the area as having scored a 10 on the which indicated.  ed 11/24/18 at 23:36 (11:36 esident was admitted to as notified of his status. DON) was informed."  with the social worker on she stated, Resident #103 th a notice of discharge nor the Ombudsman.  ed to provide Resident #103 es of discharge and send a the Ombudsman.  Policy Before/Upon Trnsfr (2)  if bed-hold policy and returnations a resident to a hospital or a therapeutic leave, the provide written information to ent representative that  e state bed-hold policy, if a resident is permitted to esidence in the nursing	F 6	F 625 Notice of Bed Hold policy  1. Resident # 21, # 31, # 2 35, # 41, #17, # 57 and 103 Written notification the bed hold policy has been provided to the resident/and or	and retu	5/31 2019 Jurn	
	(ii) The reserve bed plan, under § 447.40	payment policy in the state of this chapter, if any; ity's policies regarding		Responsible party, Began on 4/16/2019 by the Admission Director.	al net transition and the second seco		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
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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-fithe time of transfer of hospitalization or the facility must provide resident represental specifies the duration described in paragra. This REQUIREMEN by:  Based on staff interreview, and clinical of the determined that facility mitter notification of time of a facility-initial residents in the survey 22, , 35, 41, 17, 57, 1. The facility staff facor the resident's reprofithe bed hold policy transferred to the hold.  The facility staff facor the resident's reprofithe bed hold policy transferred to the hold.  The facility staff facor the resident's reprofithe bed hold policy transferred to the hold.	hich must be consistent with this section, permitting a not specified in paragraph (e)(1) mold notice upon transfer. At of a resident for erapeutic leave, a nursing to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section. It is not met as evidenced view, facility document record review, it was lity staff failed to provide a the bed hold policy at the ted transfer for 8 of 44 resentative written notification by when the resident was spital on 1/13/19.  It is not met as evidenced with the test of the bed hold policy at the te	F 6	2. Resider transfer to the hotel potential to ensure hold polion or be a conducted nurses, Acand Social	of resident ge/ transfer to the lover last 3 month re a written bed licy has been given before 5-30-19 7/2019 Re-Inservice Dicensee on bed licy, process of ion at the time of sfer and bed hold viewed with legional Director of operations.  2019 Re-training old policy will be d for License dmission Director of license dmission Director	S		
ŀ	transferred to the ho	o provide Resident #35 with		Operations	S.	, , , , , , , , , , , , , , , , , , ,		

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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	4/16/2019	
GREEN	BRIER REGIONAL ME	DICAL CENTER			017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	ни		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	a written notice of the upon transfer to the 5. The facility staff f. Notice to Resident is hospital on 1/18/19.  6. The facility staff fibed hold to Resident the hospital.  7. The facility staff fibed hold to Resident the hospital.  8. The facility staff fibed hold prior to Restransferred to the hospital.  8. The facility staff fibed hold prior to Restransferred to the hospital.  1. Resident #21 was 11/3/17 and readmit diagnoses that including blood pressure, Resident #21's most set) assessment with an date) of 1/28/19. Resident #21's most set) assessment with an date) of 1/28/19. Resident #21's most set) assessment with an date) of 1/28/19. Resident #21's most set) assessment with an date) of 1/28/19. Resident #21's most set) assessment with an date) of 1/28/19. Resident #21's most set) assessment with an date) of 1/28/19. Resident #21's most set in the Staff Assessment with an date) of 1/28/19. Resident #21's most set in the staff Assessment with an date) of 1/28/19. Resident #21's most set in the staff Assessment with an date) of 1/28/19. Resident #21's most set in the staff Assessment with an date) of 1/28/19. Resident #21's most set in the staff Assessment with an date) of 1/28/19. Resident #21's most set in the staff Assessment with an date) of 1/28/19. Resident #21's most set in the staff Assessment with an date) of 1/28/19. Resident #21's most set in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an date in the staff Assessment with an an an an an an an an an an an an an	he facility's Bed-Hold Policy hospital 12/18/18.  ailed to provide a Bed-Hold #41 upon discharge to the ailed to provide a notice of it #57 who was transferred to failed to provide a notice of t #17 who was transferred to ailed to provide a notice of ailed to provide a notice of sident #103 who was spital.	F6	325	4. Bed hold audit will be conducted 1 x week x 4 weeks, then 1 x month by DON/Administrator/desig ed  The audits will be documented and maintained in the Administrator's office  Results of the training and audits will be presented Monthly to the QAPI committed by The Administrator and/or DON	n d		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495330	B. WING				С
NAME OF	PROVIDER OR SUPPLIER		101111111		REET ADDRESS, CITY, STATE, ZIP CODE	04	/16/2019
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GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	(emergency room) of Responsible party (confined message on phone. ER (emergency room) of Review of Resident evidence that the best the resident at the time of the resident at the time of the resident at the time of the resident at the time of the resident at the time of the resident at the time of the resident at the time of the resident at time of the residents at tim	sic) order to send to ER for evaluation and treatment. Son) notified, DON (Director by this nurse leaving. Report called into (Name of m)."  #21's clinical record failed to ed hold policy was sent with me of transfer to the hospital.  A.M., an interview was a (administrative staff eON (assistant director of ed what paperwork was sent e of a transfer to the hospital, nurses will fill out and send an en, an SBAR (situation, ment, recommendation) enistory and physical, bed hold ment labs, orders etc. When do know that the bed hold the resident upon transfer to 2 stated that nurses should the clinical record that the bed with the resident. ASM #2 not documented anywhere in at the bed hold policy was at, then it was not done.	Fe	525			
	the DON (Director of of the above concerr 2. The facility staff fa or the resident's repr	iled to provide Resident #31		A y principal and made declaration reasons as management of the principal pr			
	of the bed hold policy transferred to the ho	y when the resident was spital on 1/18/19.					

	1 40	(X3) DATE SURVEY COMPLETED	
495330 B. WING	C		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COE	04/16/2019		
GREENBRIER REGIONAL MEDICAL CENTER  1017 GEORGE WASHINGTON HIGHWAY CHESAPEAKE, VA 23323			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	N	
F 625 Continued From page 74 F 625			
Resident #31 was admitted to the facility on 1/10/19 and readmitted on 1/22/19 with diagnoses that included but were not limited to Alzheimer's Disease, type one diabetes, high blood pressure and psychotic disorder. Resident #31's most recent MDS (minimum data set) assessment was a significant change assessment with an ARD (assessment reference date) of 2/3/19. Resident #31 was coded as being severely impaired in cognitive function on the Staff Assessment for Mental Status Exam.  Review of Resident #31's nursing notes, revealed that she had been transferred to the hospital on 1/18/19. The following note was written: "v/s (vital signs) 99.7, 64 (pulse), 16 (respirations), 103/66 (blood pressure) Resident had 2 episodes of vomiting this eve (evening) shift. On call NP (nurse practitioner) called and a new order was given for Zofran (1) 4 mg (milligrams) po (by mouth) q (every) six hours prn (as needed) for nausea and vomiting, STAT (immediate) KUB (2) labs to draw CBC (complete blood count) (3), CMP (complete metabolic panel) (4), amylase (5) ans (sic) lipase (6) levels. Cont (continue) on PO (by mouth) abt (antibiotics) with no adverse reactions noted. KUB done this shift, awaiting results."  Review of the KUB results documented the following: "Mild Paralytic ileus (6)."  The next note dated 1/18/19 documented the following: "Resident sent to ER (emergency room) for evaluation to KUB results. RP (responsible party) aware."			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		STREET ADDRESS, CITY, S 1017 GEORGE WASHING CHESAPEAKE, VA 23:	STON HIGHWAY NO		/16/2019
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	evidence that the beauther resident at the to the resident at the to the resident at the to the resident at the to the resident at the to the the the the the the the the the the	ed hold policy was sent with ime of transfer to the hospital.  A.M., an interview was a (administrative staff DON (assistant director of ted what paperwork was sent ne of a transfer to the hospital, nurses will fill out and send an m, an SBAR (situation, sment, recommendation) history and physical, bed hold inent labs, orders etc. When d know that the bed hold in the resident upon transfer to the clinical record that the bed to with the resident. ASM #2 not documented anywhere in nat the bed hold policy was nt, then it was not done.  D.m., ASM (administrative ne administrator and ASM #4, of Nursing) were made aware	F 6	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY
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NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE			1 04/	10/2019
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GREENE	BRIER REGIONAL ME	DICAL CENTER			CHESAPEAKE, VA 23323	MIN	
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F 625	,		Fθ	325			
	(3) CBC -Your blood	contains red blood cells					-
	(RBC), white blood	cells (WBC), and platelets.					
	Blood count tests m	easure the number and types					
	of cells in your bloo	d. This helps doctors check on					
	your overall health.	The tests can also help to					
		and conditions such as					-
		clotting problems, blood			The second secon	}	
		ne system disorders. This ained from The National					
	Institutes of Health.	ained from the National					
		n.nih.gov/pubmed/3537252.					
	(4) CMP-A group of	blood tests that measures			# # # # #		
	several parameters.	including blood sugar					
	(glucose), proteins.	electrolytes (such as sodium					
	and potassium), wa	ste products (such as blood					
	urea nitrogen [BUN]	and creatinine), and			To the second se		
	enzymes. The comp	rehensive metabolic panel					
	(CMP) is used to as	sess overall health and to					
	diagnose and guide	treatment of numerous			Year and the second sec		
		mation was obtained from					
	The National Institut			:	The second secon		
	https://aidsinfo.nih.g	ov/understanding-hiv-aids/glo			•		
	ssary/2992/comprer	ensive-metabolic-panel.					
	(5) Amyaise and Lip	pase- The diagnosis of acute					
	of the three disance	the presence of at least two tic criteria - characteristic					
	abdominal nain ele	/ated serum amylase or					
	linase and radiologi	cal evidence of pancreatitis.					
	This information was	s obtained from The National					1
	Institutes of Health.	obtained from the reasonal					
İ		ı.nih.gov/pmc/articles/PMC46				1	
	53980/.					1	į
Ì	(6) Mild Paralytic ileu	is is a condition in which the				Ì	
	muscles of the intes	tines do not allow food to		ļ		l	
***************************************	pass through, resulti	ng in a blocked intestine.		į			
an Action	Paralytic ileus may b	e caused by surgery,		4			1
1	intiammation, and co	ertain drugs. This information		Í		***************************************	1
		he National Institutes of		ļ			l
	Health.	Paris and Paris		-			

	TOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE			
GREENE	BRIER REGIONAL ME	DICAL CENTER		•	017 GEORGE WASHINGTON HIGHWAY NO	RTH		
			,	C	CHESAPEAKE, VA 23323			
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 625	Continued From page 77 https://www.cancer.gov/publications/dictionaries/cancer-terms/def/paralytic-ileus.		F 6	325				
				AN ANTHONY WHEN THE				
	or the resident's rep	ailed to provide Resident #22 presentative written notification by when the resident was pospital on 3/4/19,						
A CALL	1/13/17 and readmit that included but we disorder, severe par	dmitted to the facility on ted on 3/6/19 with diagnoses are not limited to anxiety ic disorder, muscle					Proposition to the design of the state of th	
mana — wayoo baasho siin-bb tuu	#22's most recent M assessment was a c	betes (type two). Resident IDS (minimum data set) quarterly assessment with an						
	Resident #22 was co impaired in cognitive	eference date of 1/31/19.  oded as being moderately function scoring 11 out of 15 interview for Mental Status)				:		
***************************************	that she had been to 3/4/19. The following (Laboratory) results care-physician) rega	#22's nursing notes, revealed ansferred to the hospital on g was documented: "Labs call in to LTC (long term rding Glucose (sugar) Critical se (Name of On call nurse)						
	The next note dated	3/4/19 documented the ident to ER for evaluation of				1/20		
1	evidence that the be	#22's clinical record failed to d hold policy was sent with ne of transfer to the hospital.		The state of the s		The state of the s		
1	On 4/12/19 at 9:57 A	.M., an interview was		NAV THE BEST OF THE STATE OF TH			ĺ	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY
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GREENE	BRIER REGIONAL ME	DICAL CENTER		1	1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
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	conducted with ASA member) #2, the AE nursing). When ask with residents at tim ASM #2 stated that INTERACT tool forr background, assess form, the residents policy, and any pertiasked how we would policy was sent with the hospital, ASM # be documenting in thold policy was sent stated that if it was at the clinical record the sent with the resident with the resident with the resident with the DON (Director of the above concer 4. Resident #35 was facility 10/4/15, and 12/31/18, after an accurrent diagnoses in hemiparesis, GERD The quarterly Minimassessment with an (ARD) of 2/7/19, coccompleting the Brief (BIMS) and scoring and Resident #35's daily were severely impair.	M (administrative staff DON (assistant director of sed what paperwork was sent he of a transfer to the hospital, nurses will fill out and send an m, an SBAR (situation, sment, recommendation) history and physical, bed hold inent labs, orders etc. When d know that the bed hold in the resident upon transfer to the clinical record that the bed t with the resident. ASM #2 not documented anywhere in that the bed hold policy was int, then it was not done.  D.m., ASM (administrative the administrator and ASM #4, of Nursing) were made aware the so originally admitted to the twas readmitted to the facility cute care hospital stay. The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.  The included; diabetes, and Alzheimer's disease.	Fe	625			
		ing extensive assistance of y, total care of two with					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Į	ILTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 1017 GEORGE WASHINGTON HIGHW CHESAPEAKE, VA 23323			/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE ACTION S	HOULD I	BF	(X5) COMPLETION DATE
	transfers, total care dressing, personal in the discharged of the clinical note dated 12/18/18 review of the clinical note dated 12/18/18 resident #35 was a deep sleep and abnuadministered for temphysician was made condition/abnormal in treatment was administered for temphysician was made condition/abnormal in treatment was administered again. The pransfer the resident hospital for evaluation the above findings in Administrator, Direct Corporate Consultar approximately 1:40 postated at the time of transfer the facility stated at the time of transfer the facility stated at the requirement and of the requirement and of the requirements.  5. The facility staff for Notice to Resident #41 was a feeting personal in the region of the region of the region of the region of the requirements.	of one with eating, locomotion hygiene, toileting and bathing.  arge MDS assessment dated Resident #35 was of anticipated.  al record revealed a nurse's at 7:55 p.m., which stated seessed at 5:35 p.m., in a formal vital signs. Tylenol was apperature and the on-call aware of the resident's vital signs. A nebulizer instered for wheezing and erefore the physician was only sician gave an order to to the local acute care on and treatment.  Were shared with the for of Nursing and the int on 4/16/19 at it.m., the Director of Nursing Resident 35's hospital traff was not aware of the de written information to the ent representative of the licy but; in late February or in-serviced the facility's staff and how they would meet the lailed to provide a Bed-Hold 41 upon discharge to the	F	625			
1:	facility originally on 4	/6/15 and readmitted on es to include but not limited				relly them we removed a may	

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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		495330	B. WING	3		1	/16/2019
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI			
GREEN	BRIER REGIONAL ME	DICAL CENTER	:	1017 GEORGE WASHINGTON HI CHESAPEAKE, VA 23323	IGHWAY NOI	RTH	
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 625	to Dysphagia (difficed Depressive Disorder and Dementia.  The most recent Minassessment was a Subsessment Refere The Brief Interview of a 4 out of a possible has severe cognitive MDS submit history documented in part,  1. Unplanned Hosp Anticipated Assessment.  Participated Assessment.  Facility Entry Assessment.  Resident #41's Progrand are documented.	ulty swallowing), Major r, Type 2 Diabetes Mellitus nimum Data Set (MDS) Significant Change with an nce Date (ARD) of 1/29/19. for Mental Status (BIMS) was a 15, indicating Resident #41 is impairment. Resident #41's was also reviewed and is as follows: ital Discharge Returnment with ARD of 1/18/19. essment with ARD of ress Notes were reviewed in part, as follows:	F	625			
	amounts of beige co diminished lung sour nasal congestion. re Name (hospital) at 4 1/18/19 14:37 (2:37) Name (hospital) with On 4/12/19 at approx Assistant Director of if a Bed-Hold Notice resident upon discha 1/18/19. The ADON documentation that tisent."	lored phlegm, emesis X3, nds right side upper lobes, esident transported via 911 to					

A95330  NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAY NORTH  CHES APEANS NA 20202	AND PLAN	NT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		E SURVEY IPLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  GREENBRIER REGIONAL MEDICAL CENTER  1017 GEORGE WASHINGTON HIGHWAY NORTH			495330			1	_
GREENBRIER REGIONAL MEDICAL CENTER  1017 GEORGE WASHINGTON HIGHWAY NORTH	NAME OF	F PROVIDER OR SUPPLIER				04/	16/2019
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CHESAPEAKE, VA 23323	GREEN	VORIER REGIONAL ME	DICAL CENTER		CHESAPEAKE, VA 23323	*1111	
TAG REGIL ATORY OR & COMPENTICIAN DEPORT FOR PROPERTY (EACH CORRECTIVE ACTION SHOULD BE COMP	PREFIX	( EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(XS) COMPLETION DATE
F 625 Continued From page 81 last revised on 3/2017 was reviewed and is documented in part, as follows:  Policy Statement: Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold policy and return policy.  3. Prior to a transfer, written information will be given to the residents and the resident representatives that explain in detail: a. The rights and limitations of the resident regarding bed-holds; b. The reserve bed payment policy as indicated by the state plan (Medicaid residents); c. The facility per diem rate required to hold a bed, or to hold a bed beyond the state bed-hold period, and d. The details of the transfer.  On 4/16/19 at 1:25 P.M. a pre-exit debriefing was held with the Administrator, the Director of Nursing and the Regional Director of Operations were the above information was shared.  Prior to exit no further information was presented by facility staff. 6. Resident #57 was re-admitted to the facility on 1/28/19 with diagnoses which included a history of sepsis due to Escherichia coli (E.Coli) esophagitis, muscle weakness, dysphagia, abnormalities of gait, hypertension, COPD, depression, diabetes, cardiovascular disease, hyperlipidemia, and contractures of left hand. The facility staff falled to provide Resident #57 with a notice of bed hold policy prior to transfer to a hospital.		last revised on 3/20 documented in part  Policy Statement: Prior to transfers an residents or resident informed in writing of return policy.  3. Prior to a transfer given to the resident representatives that a. The rights and lir regarding bed-holds b. The reserve bed by the state plan (Mc. The facility per di bed, or to hold a be period, and d. The details of the On 4/16/19 at 1:25 f held with the Admini Nursing and the Regwere the above informality staff.  6. Resident #57 was 1/28/19 with diagnos of sepsis due to Esc esophagitis, muscle abnormalities of gait depression, diabetes hyperlipidemia, and of facility staff failed to notice of bed hold portion of sepsis due to be separated to the second of sepsis due to be second of sepsis due to be second of second of sepsis due to be second of secon	17 was reviewed and is as follows:  In the definition will be of the bed-hold policy and the resident explain in detail: mitations of the resident explain in detail: mitations of the resident; payment policy as indicated edicaid residents); em rate required to hold a depend the state bed-hold extransfer.  P.M. a pre-exit debriefing was strator, the Director of operations from all Director of Operations from was shared.  Pre-admitted to the facility on the session was presented extra the provide Resident #57 with a provide Resident #57 with a	F 6:			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		E SURVEY	•
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	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		/16/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	A re-entry Minimum 2/25/19 assessed the difficulties in the area or understanding arth the area of Cognicassessed for a brief (BIMS) and scored at A Nursing note date indicated: "Pt complete ars. Pt. stated that all week but pt has f does have Foley that urine. Foley was flusty pain noted by pt. Pt to decrease pain with sent out to ER for exist self responsible, conotified. Resident trainedical to hospital.  During an interview of 4/11/19 at 2:55 P.M. was not provided with the adischarge to the adischarge to the The facility staff to provide of bed hold potential. The facility staff to provide of bed hold potential. The facility staff to provide of bed hold potential. The facility Resident #17 with a resident #17 with a facility Resident as having not difficulty. Resident #18	Data Set (MDS) dated his resident as having no he aring, speech, vision and the ability to be understood. At the ability to be understood. The ability to be	F6	25				

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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F 625	resident was assess 15.  A Nursing Note date P.M.) indicated: "CN came and got this nor room because some walking into the resisting up in the chaic over her chest and I side and her eyes we calling out the residerespond but just loo	sed as having a BIMS score of ad 4/8/19 at 22:45 (10:45 NA (certified nursing assistant) curse to go into the residents ething was wrong. When idents room the resident was ir slummed over with vomit all her mouth was over to the vere open. This nurse kept ents name the resident did not ked at this nurse but did not		325			
	say anything. Got not When calling the residid not respond to his moved around. We so her with HOB ele CNA got vitals within skin was cold and cohecked read at 186 the room to see the	urse from the unit to help. sidents name the resident still er name, she just looked and then repositioned the resident evated to about 65 degrees. In normal range the residents elammy, blood sugar was S. Supervisor was brought to condition of the resident. 911 ensible parties were called					
	4/11/19 at 2:55 P.M. was not provided wit prior to a hospital tra  The facility staff faile	d to provide Resident #17					
	8. Resident #103 wa 4/26/18 with diagnos mellitus, dysphagia, neuropathy, and ove	y prior to a hospital transfer. s admitted to the facility on es of hypertension, diabetes cardiovascular accident, r active bladder. The facility Resident #103 with a bed hospital transfer.		o de la companya de l		an construction to the property of a construction of the construct	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		TE SURVEY MPLETED		
		495330	B. WING			1	C		
	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 625	Continued From pa	ge 84	F6	325					
		essed this resident in the area as having scored a 10 on the					Address of the Control of the Contro		
	P.M.) indicated: " R	ed 11/24/18 at 23:36 (11:36 esident was admitted to as notified of his status. DON ) was informed."							
	4/11/19 at 2:55 P.M	with the social worker on . she stated, Resident #103 th a bed hold policy prior to a hospital.							
F 640	with a bed hold police a hospital. Encoding/Transmitti	ed to provide Resident #103 cy prior to being transferred to ing Resident Assessments	F 6	40					
	§483.20(f) Automate requirement- §483.20(f)(1) Encode a facility completes a facility must encode each resident in the (i) Admission assessicii) Annual assessmiciii) Significant changicii) Quarterly review (v) A subset of items reentry, discharge, a (vi) Background (facis no admission assessino admission admission assessino admission	ed data processing ling data. Within 7 days after a resident's assessment, a the following information for facility: sment. ent updates. ge in status assessments. assessments. as upon a resident's transfer, and death. e-sheet) information, if there essment.		edit in it to a to a to a to a to a to a to a t					
	§483.20(f)(2) Transr after a facility comple	nitting data. Within 7 days etes a resident's assessment,		- Andreadash as seemed as the					

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
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		495330	B. WING		-	0.4	/16/2019	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 04	710/2019	
GREENE	BRIER REGIONAL ME	DICAL CENTED			7 GEORGE WASHINGTON HIGHWAY NO			
	THE THE STATE OF T			CH	ESAPEAKE, VA 23323			
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 640	Continued From pa	ge 85	Fe	640				
	a facility must be ca CMS System inform contained in the MD standard record laye	pable of transmitting to the pation for each resident PS in a format that conforms to puts and data dictionaries, and data defined by			640 Encoding/ Transmitting	r	The state of the s	
		ļ		R	esidents Assessments			
	14 days after a facili assessment, a facili encoded, accurate, the CMS System, in (i)Admission assess (ii) Annual assessment (iii) Significant chang (iv) Significant correct (v) Significant correct (v) Significant correct (vi) Quarterly review (vii) A subset of item reentry, discharge, a (viii) Background (facinitial transmission of does not have an additional transmission of the control of th	ent, ge in status assessment, ction of prior full assessment, ction of prior quarterly s upon a resident's transfer, and death, ce-sheet) information, for an f MDS data on resident that mission assessment.		2	<ul> <li>Resident #1's 1/25/2019 Annu Minimum Data Set (MDS) Asso was reviewed and correctly transmitting the Medicaid system on 4/12/201 MDS coordinator.</li> <li>All residents have the potential affected.</li> <li>MDS Coordinators will be in-set transmitting the MDS within 7 completion of the MDS</li> </ul>	essmer ansmit edicare 9 by th al to be erviced days c	ted e/ ne	
	transmit data in the f for a State which has by CMS, in the forma approved by CMS. This REQUIREMEN' by: Based on clinical red and review of the fact failed to electronically complete Minimum E Centers for Medicare	ormat. The facility must cormat specified by CMS or, is an alternate RAI approved at specified by the State and it is not met as evidenced cord review, staff interview, ility's policy the facility staff of transmit encoded and loata Set (MDS), data to the eliment Medicaid System, for 1 of the must be survey sample		5.	ensure MDSs are completed in manner and that they are tran within 7 days of completion. Rethe training and audits will be presented monthly to the QAP committee by the Administrate DON	a time smitte esults	d of	

STATEMEN AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED	
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	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	AY NORTH		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 640	Continued From pa	ge 86	Fé	640				
	The facility's staff fa encoded 1/25/19, a (MDS) assessment	illed to transmit Resident #1's nnual Minimum Data Set						
	The findings include	ed:					Andread to a large of the state	
	11/25/16 and was di							
Taliya di Mahadan di Mayaya Angala a mama da ka ka ka ka ka ka ka ka ka ka ka ka ka	coded the resident a Interview for Mental out of a possible 15, cognitive abilities for intact. In section "G"	ce date (ARD) of 10/25/18, as completing the Brief Status (BIMS) and scoring 15 This indicates Resident #1's daily decision making were (Physical functioning) the as independent with all						
-	#1 triggered for not l completed in greater MDS assessment ac was dated 10/25/18)	Assessment review Resident naving a MDS assessment than 120 days (the prior cepted in the CMS databank, therefore an interview was MDS Coordinator on 4/11/19, 0 p.m.						
	annual MDS assessi was in the computer, and showed it had be send). The MDS Coounable to locate the CMS databank indicates.	or stated Resident #1's ment with an ARD of 1/25/19, it was completed 2/7/19, een exported (batched to ordinator stated she was validation report from the ating the 1/25/19, eepted or rejected. The MDS						

STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	ILTIPLE CONSTRUCTION DING		(X3) DAT	E SURVEY
		495330	B. WING			1	C <b>/16/2019</b>
1	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	DICAL CENTED	J	STREET ADDRESS, CITY, STATE, ZI 1017 GEORGE WASHINGTON HI			10/2019
GILLIAL	PHICH REGIONAL ME	DICAL CENTER		CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD HE APPROPI	BE:	(X5) COMPLETION DATE
F 641 SS=D	Coordinator stated a software company to 1/25/19, MDS assess to transmit it the CM approximately 11:15 present Resident #1 MDS assessment a revealing it had bee.  The above findings Administrator, Direct Corporate Consultar approximately 1:40 no additional information additional information and the facility's policy to the MDS" dated 9 electronic submission accordance with currect accordance with currect accordance with currect accordance of Assessing CFR(s): 483.20(g)  §483.20(g) Accuracy The assessment mure sident's status. This REQUIREMEN by:  Based on observation action of the staff interviews, and the facility staff failed Set (MDS) assessment resident's status at the soft of the soft of the status at the soft of the soft o	she had reached out to their o aid her in unlocking the sament so she could attempt IS databank. On 4/12/19, at 5 a.m., the MDS Coordinator I's submitted 1/25/19, annual nd the CMS validation report in accepted.  Were shared with the tor of Nursing and the nt on 4/16/19 at p.m. The facility staff provided ation.  Ittled "Electronic Transmission I/2010, read at #5; MDS ons shall be conducted in rent Omnibus Budget egulations governing the in data. ments	F6	640			
A MANAGEMENT AND A STATE OF THE	1. The facility staff fa	iled to assure Resident #11's					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY		
							С		
		495330	B. WING			2	/16/2019		
NAME OF	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		10/2010		
GREENE	BRIER REGIONAL ME	DICAL CENTER	ĺ		GEORGE WASHINGTON HIGHWAY NO	RTH	•		
	0///		<u> </u>	CHE	ESAPEAKE, VA 23323				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 641	Continued From pa	ge 88	F 6	41					
	1/14/19, quarterly N accurately coded at Restraints).	IDS assessment was section "P0100" (Physical				÷	of definition and warmer to a pain where		
	7 The feetility staff (		ł	F 641	Accuracy of Assessments	•			
	2. The facility staff failed to ensure that Resident #41's Quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 2/8/19 was accurately coded under Section "P" (Restraints and Alarms).  The findings included:			1.	Resident #11's Quarterly MD	S			
					assessment 1/14/2019 coding	g undei	•		
					Physical Restraints was corre	cted on			
				4/16/2019. Resident #41 Quarterly MDS					
177 E					with an ARD date of 2/8/2019				
Ì	Resident #11 was originally admitted to the		under Restraints and alarms was						
	facility 3/12/15 and r	eadmitted 4/12/17 after an			corrected on 4/16/2019				
İ	acute care hospital	stay. The current diagnoses		2.	All residents have the potenti	al to be	٠		
	and cerebral palsy.	disability, right hemiparesis			affected.	u1 (O D			
	•			3.	On 5/3/2019 training was pro	vided t	n.		
	The quarterly Minim	um Data Set (MDS)			the MDS Coordinator by the F				
ļ	(ARD) of 1/14/19, co	assessment reference date		:	RAI Consultant on Accuracy of		'		
	completing the Brief	Interview for Mental Status			coding on 4-16-2019	MIDS			
	(BIMS) and scoring	15 out of a possible 15. This		4	MDS accuracy audits will be o	anduct	od		
ļ	Indicates Resident #	11's cognitive abilities for g are intact. In section "G"		٦.	by the Regional RAI Director 1				
	(Physical functioning	i) the resident was coded as					1		
	requiring supervision	of one person with eating,			4 weeks then 1 x monthly x 4		•		
		e of one person with bed			then quarterly. The audits will				
	mobility, transfers, to	comotion, dressing, and d total care with toileting, and			documented and maintained i				
	bathing. On the 1/14	/19, MDS assessment in			Administrator's office, Results				
1	section "P0100" (Phy	sical Restraints). Resident			training and audits will be pre-		1		
	#11 was coded as ut	ilizing a limb restraint daily.			monthly to the QAPI committe	e by th	ne		
	On 4/11/19 at 12-20 :	p.m., the resident was			Administrator and / or DON				
		g room during lunch; the		5.	Completion Date 5/31/2019				
	resident presented w	rith right upper extremity				ŧ			
	hemiparesis, no type	of restraint was observed in							
1	use. Again on 4/12/1	9 at approximately 12:15		i		1	1		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495330	B. WING	i		1	С
	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		10	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Continued From pa	=	Fé	341			
	p.m., resident #11 v room during the lun was not observed.	as observed in the dining ch meal, use of a restraint					
	summary revealed	2019, physicían order orders for a right hand palm e to be donned/doffed by					Mary of the behavior of the company of the throughout of the throu
	9/20/18, which read self-care performan- intellectual ability an read; the resident w appropriate use of a ADL functional care	d history of stroke. The goal		AND AND AND AND AND AND AND AND AND AND			
	Coordinator on 4/15, p.m. The MDS Coordinator on the MDS Coordinator of the palm protector and the restraints therefore the modified. On 4/16 a.m. the modified 1/10 the modif	nducted with the MDS /19 at approximately 1:30 dinator stated the coding for sed daily was incorrect for the he pommel cushion are not he MDS assessment would 6/19 at approximately 10:30 14/19 MDS assessment was ger was coded that resident a limb restraint daily.		A destruction of the second se			
	Corporate Consultar	or of Nursing and the at on 4/16/19 at o.m. The facility staff provided				Am Hayley (Aghar Alab Marco et la manaman de Agrades Agrades Acades	
1	the Resident Assess	tied "Certifying Accuracy of ment" dated 12/2009 read; mplete any portion of the					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUC			E SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER	1,0000	J 5. W. 10			04/	/16/2019
1,7,5,1,2,0,1	. TO THE ETT OF THE ETT				ESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			E WASHINGTON HIGHWAY NO KE, VA 23323	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACI	IOVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
200	Resident Assessment.  2. Resident #41 was the facility originally 1/22/19 with diagno to Dysphagia (diffict Depressive Disorde and Dementia. Res Restraints under MI Indicators.  The most recent Min was a Significant Chraference Date (AF Interview for Mental a possible 15, indica cognitive impairment Resident #41's Qua 2/8/19 was reviewed as follows:  Section P Restraints P0100 Physical Res c. Limb Restraint: 1  On 4/11/19 at 4:00 F conducted with the N Resident #41 being 2/8/19 Quarterly MD stated, "A MDS Coothat help us prn (as That is an error on the states of the section of the sec	ent (MDS) must sign and of that portion of the as a 84 year old admitted to on 4/6/15 and readmitted on ses to include but not limited ulty swallowing), Major er, Type 2 Diabetes Mellitus sident #41 was triggered for DS (Minimum Date Set)  nimum Data Set assessment nange with an Assessment RD) of 1/29/19. The Brief Status(BIMS) was a 4 out of ating Resident #41 has severe at.  rterly MDS with an ARD of d and is documented in part,	F6	41			
	The Modified Quarte completed on 4/11/1	erly MDS for 2/8/19 was 9. Under Section P		- Company of the Comp			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04/	/16/2019
	BRIER REGIONAL ME	DICAL CENTER		10	017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
F 641	Continued From page	ge 91	F 6	i41			
	Restraints and Alarr	ns, P0100 Physical Restraints oded as 0-Not Used.					a casa de l
	Resident Assessme	ed "Certifying Accuracy of the nt" revised 12/2009 was umented in part, as follows"					
	any portion of the Ro	Il personnel who complete esident Assessment (MDS) y the accuracy of that portion					
	MDS assessment, to request form must s	o complete any portion of the racking form, or correction ign a hard copy of such og the accuracy of that portion		***************************************			
	held with the Adminis	P.M. a pre-exit debriefing was strator, the Director of pional Director of Operations mation was shared.					
F 645 SS=E	Prior to exit no further facility staff. PASARR Screening CFR(s): 483.20(k)(1)	er information was shared by for MD & ID -(3)	F 64	45		And the state of t	
The state of the s	§483.20(k) Preadmis individuals with a me with intellectual disat	ntal disorder and individuals				nem deronsande primapa popularisma ama	-
	or after January 1, 19 (i) Mental disorder as (i) of this section, unl authority has determine	ing facility must not admit, on 989, any new residents with: s defined in paragraph (k)(3) ess the State mental health ined, based on an and mental evaluation				A THE PARTY OF THE	

A95330  B. WING  TREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 645  Continued From page 92 performed by a person or entity other than the State mental health authority, 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  A95330  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323  F 645 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECT		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		E SURVEY MPLETED
REENBRIER REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 645  Continued From page 92 performed by a person or entity other than the State mental health authority, 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			495330		· · · · · · · · · · · · · · · · · · ·	1	_
GREENBRIER REGIONAL MEDICAL CENTER  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 645  Continued From page 92 performed by a person or entity other than the State mental health authority, 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	NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	16/2019
(X4) ID PREFIX TAG    SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG     F 645   Continued From page 92 performed by a person or entity other than the State mental health authority, 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     F 645   PREFIX TAG     P	GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY NO	)RTH	
performed by a person or entity other than the State mental health authority, 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	PRÉFIX	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTIO  ( (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP	) BE	COMPLETION
specialized services; or  (ii) Intellectual disability, as defined in paragraph (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 specialized services for intellectual disability.  §483.20(k)(2) Exceptions. For purposes of this section- (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 being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in		performed by a persolate mental health (A) That, because of condition of the individual the level of services and (B) If the individual services, whether the specialized services (ii) Intellectual disability authority has determ (A) That, because of condition of the individual reservices, whether the level of services and (B) If the individual reservices, whether the specialized services §483.20(k)(2) Exception—(i)The preadmission paragraph(k)(1) of the determinations in to a nursing facility of the state may characteristic of the preadmission screen paragraph (k)(1) of the anursing facility of (A) Who is admitted hospital after receiving the preadmission in the state may characteristic of the state may characteristic of the state may characteristic of the state may characteristic of the state may characteristic of the state may characteristic of the state may characteristic of the state may characteristic of the state may characteristic of the state may characteristic of the state of the st	authority, prior to admission, of the physical and mental vidual, the individual requires a provided by a nursing facility; requires such level of the individual requires are individual requires are developmental disability and prior to admission of the physical and mental vidual, the individual requires provided by a nursing facility; requires such level of the individual requires provided by a nursing facility; requires such level of the individual requires for intellectual disability. The physical and mental vidual, the individual requires for intellectual disability. The physical and mental vidual, the individual requires for intellectual disability. The physical and program under the case of the readmission of an individual who, after the nursing facility, was in a hospital. The physical program under the section to the admission of an individual to the facility directly from a negligible acute inpatient care at the resing facility services for the	F6	F 645 PASARR Screening for ME MI  1. Resident # 104 Level 1 PA screen will be completed a submitted for determination on or before 5-30-19  Resident # 68 Level 1 PASSA will be completed and submitted for determination or before 5-30-19  Resident # 83 Level 1 PASARE will be completed and submitted for determination or before 5-30-19  2. Review of resident admitted to the facility for Level 1 PASSAF began on 4/22/2019 by the DON/ADON. All residents could	SSAR nd on AR on on	

STATEMENT AND PLAN (	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION  G	(X3) DAT COA	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER BRIER REGIONAL MÉ	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY CHESAPEAKE, VA 23323		10,2015	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	the hospital, and (C) Whose attendir before admission to is likely to require lefacility services.  §483.20(k)(3) Definisection— (i) An individual is conferred in the individual is conferred in the individual is contellectual disability or is a person with a described in 435.10 This REQUIREMEN by:  2. Resident #104 to 03/15/19 with diagn diabetes mellitus, Nhemiplegia and seiz failed to provide a (IResident Review) (For Resident #104 for intellectual disability  An Initial Minimum II 03/29/19 assessed hearing, speech and difficulty's. In the are resident had a BIMS Functional Status Acthis resident was as mobility, transfer, dr personal hygiene as	ing physician has certified, of the facility that the individual less than 30 days of nursing sets than 30 days of nursing sets than 30 days of nursing sets than 30 days of nursing sets than 30 days of nursing sets than 30 days of nursing sets than 30 days of this considered to have an and as defined in §483.102(b)(3) a related condition as set to 10 of this chapter. The facility on sets of schizophrenia, son-Alzheimer's Dementia, cure disorder. The facility staff Preadmission Screening and PASARR) to assess the need of a mental disorder or prior to admission.  Data Set (MDS) dated Resident #104 in the area of division as having no set of Cognitive Patterns this assocre of 3. In the area of civities of Daily Living (ADL'S) sessed in the areas of bed sessing, eating toilet use and a requiring extensive erson physical assist.	F 645	3. On 5/3/2019 In-service Traprovided to the Interdiscip to include the Social Service and Admission Director on pre-admission screening, L PASSAR Admission require  4. PASSAR Audit completed 1 week x 4 weeks then 1 x m by the DON/ Administrator  The audits will be document and maintained in the Administrator's office  Results of the training and audits will be presented Monthly to the QAPI commit by The Administrator and/o DON	olinary tea ce assistant PASARR evel 1 ments. x onth		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	170000	D. 7784G			04/	/16/2019	
į					STREET ADDRESS, CITY, STATE, ZIP CODE			
GREEN	BRIER REGIONAL ME				017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
	activity involvement time for adjustment schizophrenia. Goa activities of choice. Encourage the residualities of choice. Encourage the residualities with reminders behavior problem diconcentrator; Goalepisodes of inapproreview date. Approamedications as ordeside effects and effects	sident #104 has little or no r/t new admit to facility needs. Resident has history of l- Resident to participate in Approaches/tasks - lent's participation by friendly s. Focus- The resident has a rinking water from o2. The resident will have fewer priate behaviors through the ches/ Tasks - Administer lend. Monitor/document for ectiveness.  In 4/11/19 at 2:50 P.M. with locker, she stated, Resident led with a Level I PASARR dmissions.  In a 67 year old admitted to 9 with diagnosis to include lolar Disorder, Major ry, Anxiety Disorder and rider.  In a 68 year old admitted to 9 with diagnosis to include lolar Disorder, Major ry, Anxiety Disorder and rider.  In a 68 year old admitted to 9 with diagnosis to include lolar Disorder, Major ry, Anxiety Disorder and rider.  In a 68 year old admitted to 9 with diagnosis to include lolar Disorder, Major ry, Anxiety Disorder and rider.  In a 68 year old admitted to 9 with diagnosis to include lolar Disorder, Major ry, Anxiety Disorder and rider.  In a 68 year old admitted to 9 with diagnosis to include lolar Disorder, Major ry, Anxiety Disorder and rider.	F6	145				
	making.  Resident #68's Com	I capable of daily decision prehensive Care Plan last reviewed and is documented		designad Adamentary (1944), 1944, and an analysis (1944), and an analysis (1944).		The state of the s		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı		LE CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	16/2019
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 645	<b>,</b>	ge 95  It has little of no activity	F6	i45			
	involvement related resident wishes not	to Depression, Disinterest, to participate. History of olar, prefers own leisure					
	version 2.1 was revi part, as follows: Policy Statement: (	led "Admission Criteria" lewed and is documented in Our facility admits only edical and nursing care needs					
	9. All new admission screened for mental disabilities (ID) or representation of the Medicaid Pre-Admission of the Medicaid Pre	ucts a Level I PASARR screen issions, regardless of payer if the individual meets or RD. en indicates that the individual a for a MD, ID, or RD, he or e state PASARR e Level II (evaluation and					
	conducted with the Moversees the Admiss Marketing Director s Level I PASARR for Marketing Director w facility process for old The Marketing Director when Marketing Director when Marketing Director spoke with the hospi	P.M. and interview was Marketing Director who also sion Department. The tated, "We do not have a (Name) Resident #68." The was asked what was the praining Level I PASARR's, tor stated, "Earlier this week I tal case managers and RR's (Level I's) were being				Anderstein der Gestelle der Gestelle der Gestelle des Gestelle des Gestelle des Gestelle des Gestelle des Geste	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER		·	5	STREET ADDRESS, CITY, STATE, ZIP CODE	<del></del>	10/2019
GREENE	RIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NOI CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	asked for them by for Director was asked receiving completed completing Level I F the hospital earlier to Director stated, "Not them or doing them On 4/16/19 at 1:25 I held with the Admin Nursing and the Rewere the above infor Regional Director of hired a new social was on and if the Lever received from the hobe able to complete Prior to exit no furth the facility staff.  Based on record reversely asked o	at they have just starting being acilities. The Marketing if the facility had been I Level I PASARR's or PASARR's prior to talking to his week. The Marketing we have not been receiving here for the residents.  P.M. a pre-exit debriefing was istrator, the Director of gional Director of Operations rmation was shared. The Operations stated, "We have worker who will be starting of I PASARR's are not ospital the social worker will	F6	645			
TO THE PROPERTY OF THE PROPERT	to ensure a Level I I Screening and Resid screening for a men intellectual disability	PASARR (Preadmission dent Review) a pre-admission		PARTY CONTRACTOR CONTR		THE THE PROPERTY OF THE PROPER	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 .		PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	<u>L </u>	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	10/2019
GREENE	BRIER REGIONAL ME	DICAL CENTER		•	1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 645	#104 and #68), in the facility staff #83's Level I PASA admission to the nuclear transfer admission to the n	failed to ensure Resident RR was completed prior to ursing facility.  failed to ensure Resident ARR was completed prior to ursing facility.  failed to ensure a Level 1 pleted prior to admission to the desident #68.  ed;  as originally admitted to the the resident has never been a facility. The current generating dementia, traumatic brain psychotic disorder, anxiety disorder.  aum Data Set (MDS) assessment reference date and the resident as funterview for Mental Status 19 out of a possible 15. This if 83's cognitive abilities for any was moderately impaired.  Inducted with the Social 11/19, at approximately 3:49 orker Assistant stated it wasn't care of for she was not the	F6	345		•	
	Coordinator stated of 4:30 p.m., that it was	ctor. The Admission's on 4/11/19, at approximately sn't something she asked for n process and review of the					

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER	//	<u></u>	STI	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	1/16/2019
COEEME	DIED DECIONAL ME	DICAL OFNIES			17 GEORGE WASHINGTON HIGHWAY NO	RTH	
GIILLIAL	BRIER REGIONAL ME	DICAL CENTER			IESAPEAKE, VA 23323		
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F 645	On 4/16/18, at 1:40 shared with the Adn and the Corporate C information was pro	dn't reveal the document.  p.m., the above findings were ninistrator, Director of Nursing, Consultant. No additional vided.	F 6			ì	
	be- (i) Developed within the comprehensive a (ii) Prepared by an inincludes but is not ling. (A) The attending pheroid (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prather exident and the An explanation must medical record if the and their resident report practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by the (iii) Reviewed and revitem after each assection assessments.	hensive Care Plans hensive Care Plans hersive Care Plans hersive care plan must  7 days after completion of assessment. herdisciplinary team, that mited to hysician. he with responsibility for the hersponsibility for the d and nutrition services staff. heticable, the participation of resident's representative(s). he included in a resident's participation of the resident hersponsibility for the d and nutrition services staff. heticable, the participation of resident's representative(s). he included in a resident hersponsibility for the hersponsibility	F 6	<u> </u>	<ol> <li>Care plan Timing Reviols</li> <li>Resident # 27 care plan was updated on 5-8-19 to reflect care plan problem of seizure activity, goals and Interventions by the MDS coordinator.</li> <li>All residents have the potential to be affected</li> </ol>		5/31/19

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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<u></u>		495330	B. WING	i		1	/16/2019
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREEN	BRIER REGIONAL ME	DICAL CENTER		1	1017 GEORGE WASHINGTON HIGHWAY NO	RTH	
	<u> </u>				CHESAPEAKE, VA 23323		
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E 0.57							
F 657	,	_	F 6	357	3. On 5/3/2019 Inservice		
	Based on record review, individual an				began on Care plan creat	ion	
	nlan for seizures fo	ty staff failed to develop a care rone resident (Resident #27)			•	ION	
	in the survey samp				and updating to License	•.	
					nurses by the Regional		
	The findings include	ed:			Director of Clinical		
	m				Operations.		
	Hesident #27 was a	admitted to the facility on					-
	diagnoses which in	mitted on 07/13/18 with cluded seizures, depression,			On 5/3/2019 Re-training	İ	
	anxiety, bipolar disc				_		
		hand, COPD, hypokalemia,			provide to the MDS	;	
	dementia and cardi	ovascular disease. The facility			coordinator on Timely		
	staff failed to care p	plan seizure activity for			creation, revision and		
	Resident #27.				updating of care plans by		
	A Quarterly Minimu	m Data Set dated 2/8/19			the Regional RAI Director	ļ	
	assessed this resid	ent in the area of Hearing,					
	Speech, and Vision	as makes himself understood			4. Care Plan Audit will be		
	and usually underst	ands. This resident was					
	assessed as having	impaired vision. In the area			conducted by the Regiona	•	
	or Cognitive Pattern	is this resident was assessed the Brief Interview for Mental			RAI director/MDS		
j		of Behavior this resident was	-		coordinator 1x week x 4		
		behaviors directed towards			then 1 x monthly.		1
	others, verbal behav	viors directed towards other,				ļ	
		Il symptoms not directed			The audits will be	1	
	towards others. In the	ne area of Activities of Daily			documented and		1
	requiring extensive	resident was assessed as assistance of one person in			maintained in the	ì	***************************************
		r, bed mobility, dressing, toilet			Administrator's office		ĺ
•	use and personal hy	giene. In the area of activity					
{	diagnoses this resid	ent was coded as having a			Results of the training and	.	
ĺ	diagnoses of seizure	e disorder or epilepsy.			audits will be presented	-	İ
***************************************	A ravious of the tile-	ingtion Administration D			Monthly to the QAPI	-	
***************************************	dated April 2010 ind	ication Administration Record icated: Keppra tablet 750 MG			committee by The	Ī	
Į	give two times a day	related to unspecified			•	}	ŀ
	convulsions.				Administrator and/or DON		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	04/16/2019	
GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGH CHESAPEAKE, VA 23323	WAY NOR	тн	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROI DEFICIENCY)			
F 657	Continued From page 100		F6	657	-		
		d Care Plan dated 03/27/19 als and needs for this					
	A.M.) indicated: Sei approximate 6:55 at lasting 30 seconds to to sleep. V/S 97.9-8 answering service in call. HOB (head of the	d 4/11/19 at 08:01:04 (8:01 zure activity noted at m, resident noted with tremors the started snoring and went 17-18-129/87. Physician notified, message left to return ped) elevated SR (side rails) ated with eye contact but me."					
	Resident #27 he sta	on 4/11/19 at 6:15 P.M. with ated, he was feeling much morning but got plenty of ter.					
and the second s	Coordinator she was not having a care pla	on 4/12/19 with the Care Plan s asked about Resident #27 an to address his seizure ed, "We must have missed it."					
	The facility staff faile address the goals as seizure activity. Quality of Care CFR(s): 483.25	ed to develop a care plan to nd needs of Resident #27's	F6	84			
	applies to all treatmet facility residents. Basessment of a residents received	care undamental principle that ent and care provided to sed on the comprehensive sident, the facility must ensure the treatment and care in fessional standards of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU A. BUILE		(X3) DATE SURVEY COMPLETED				
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		495330	B. WING	·		04/	/16/2019		
	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAY NORTH  CHESAPEAKE, VA 23323						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE		
	practice, the compricate plan, and the rather This REQUIREMEN by: Based on complain interviews, facility direcord review the facility of record review the facility staff failed received treatment aprofessional standa.  The facility staff failed consecutive doses of the findings included. The findings included Resident #22 was a 1/13/17 and readmit that included but we disorder, hyponatrer panic disorder, must protein-calorie main two). Resident #22's data set) assessment with an date of 1/31/19. Resident #22's data set) assessment with an date of 1/31/19. Resident #21's for Mental Status) expression of the following order for 2017 physician order (milligrams): 1 tablet daily."	ehensive person-centered esidents' choices.  IT is not met as evidenced at investigations, staff ocument review, and clinical acility staff failed to ensure that ints in the survey sample and care in accordance with rds of practice, Resident # 22.  ed to administer five of scheduled Ativan.  ed:  dmitted to the facility on atted on 3/6/19 with diagnoses are not limited to anxiety mia (low sodium), severe cle weakness, Hepatitis C, utrition and diabetes (type is most recent MDS (minimum in twas a quarterly ARD (assessment reference ident #22 was coded as a paired in cognitive function on the BIMS (Brief Interview cam.  #22's clinical record revealed or Ativan on his December in summary: "Ativan 2 MG by mouth three times a day  #22's December 2017 MAR tration Record) revealed that	F	F 684	Quality of Care  On 4/12/2019 Resident #22 In Doctor was notified of the 5 in days of Ativan not administer resident #22 on 12/9/2017 at 12/10/2017 by the Regional It Clinical Operations. The Pharm Director was notified on 4/12 the Regional Director of Clinical Operations.  All residents have the potential affected.  Nursing Staff will be in-service ordering medications 3-7 day medications run out. Nursing be in-serviced to notify the phany medications not available use the medications from the system or emergency box bot are provided by the pharmacy	doses (ind) Director macy (/2019) cal dial to be ed on s befor staff w mysician cubex h which	2) the r of by e e rill n of		

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NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STE	REET ADDRESS, CITY, STATE, ZIP CODE	<u>U4/</u>	16/2019
GREENE	BRIER REGIONAL MEI	DICAL CENTER		101	7 GEORGE WASHINGTON HIGHWAY NO IESAPEAKE, VA 23323	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	scheduled Ativan 2 times: 12/9/17 at 2 p.m., 12/9/17 at 10 p.m., 12/10/17 at 6 a.m., 12/10/17 at 2 p.m. a 12/10/17 at 10 p.m. The back of the Dec documented the folle "12/9/17 2:00 p.m. A available/pharmacy 12/9/17 10:00 p.m. A available. 12/10/17 at 6:00 a.m from pharmacy, pha 12/10/17 at 2 p.m. A available. 12/10/17 at 10 p.m. available. 12/10/17 at 10 p.m. available. 12/10/17 at 10 p.m. available. 12/10/17 at 10 p.m. available. 12/10/17 at 10 p.m. available. 12/10/17 at 10 p.m. available. Review of Resident a script for his Ativar by the physician until Review of the Decer logs revealed that his facility until 12/11/17. December 2017 nare did not receive Atival times. Review of the facility revealed that Ativan a STAT box. Review of Resident at that was sent out to the series of the series of the series of the facility revealed that Ativan a STAT box.	and sember 2017 MAR owing: Ativan 2 mg Medication not contacted. Ativan 2 mg Medication not in Ativan 2 mg Medication not in an Ativan 2 mg Medication not in a Ativan 2 mg Medication not in a Ativan 2 mg Medication not in a Ativan 2 mg Medication not in a Ativan 2 mg Medication not in a Ativan 2 mg Medication not in a Ativan 2 mg Medication not in a Medication in	F 68		Medication Administration Consults 5 x week x 4weeks then x 4 weeks then 1 x week by the DON/ADON/ designee. Narcon Controlled substance audit 3 x weeks then 1 x week by the DON/ADON/ designee. Admis Medication reconciliation audits of new admission medications include controlled substances DON/ADON/ UM 5x week. The will be documented and main the Administrator's office. Resulte training and audits will be presented monthly to the QAI committee by the Administrat DON.  Completion Date 5/31/2019	3 x we e tic/ c week sion it/ revie to by e audits tained is sults of	ek x 4 ew
	following nursing not	e was written: *12/11/17 4:46					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495330	B. WING			04/	/16/2019
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	DICAL CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION REFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
F 684	(pulse), 30 (respirat pressure), 02 sats 9 air) Resident observed presenting with seiz 2 minutes long, resit to communicate with with a blank stare by assess residents (si activity, resident not to transfer resident Room) for eval (evaresident LOA (leave via 911 stretcher, or made aware, RP (resupervisor made aw Nursing) aware will residents whereabout Review of the hospidated 12/15/17, doc "Patient is a 64 yo (quit alcohol 2 years chronic benzodiazer seizurePatient takeday) but has not had witnessed seizuwas brought to ER (mental status. Patien ER. he (sic) vomited coughing with suspicated awake but not provide according to his sist saw him three days Hospital course by put to benzo withdra Severe hyponatremi improve steadilyReference in the size of the siz	96.2 (temperature), 106 ions), 175/95 (blood 95% (percent) ORA (on room yed at about 12:56 am ture activity which lasted about dent came around but unable th staff resident, (sic) observed leeding from mouth unable to ic) mouth safely after seizure tresponding so 911 contacted to (Name of Emergency lluation) and treatment, of absence) to ER at 115 am hocall (sic) MD (medical doctor) esponsible party) made aware, vare, DON (Director of (sic) pass onto oncoming shift uts"  tal course stay summary umented the following: year old) with liver cirrhosis, ago, hep C, hyponatremia, bine use, comes in with es ativan TID (three times a dit in three days. Tonight he were with mouth bleeding. He emergency room), altered in thad another seizure in the I several times and was cloin for aspiration. Patient is ding any history which er not his baseline. She last	F6	684			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495330		B. WING		С	
MANEOE	PROVIDER OR SUPPLIER	493330	D. WING			04	/16/2019
NAMEOF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO	RTH	
	OUR DATE OF A				CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG			PREFIX (EACH CORRECTIVE ACTION SHOUL		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	8E	(X5) COMPLETION DATE
F 684	oommood i form pa		Fe	884			
	precautionI will rehyponatremia but a correctionContinu seizures with Ativan neededContinue cincluding the treatm benzodiazepine with hospitalist."  Further review of the that his sodium leve 12/11/17.  Review of Resident physical from the physical from the physical from the foll history ofseizure directions	e symptomatic treatment for 2 mg IV (intravenous) as other medical management					
	that he had a history have a history of sei ordered CMP (comp that would have sho his hospitalization we evidence that this Cl not provide this resu #22's clinical record was on fluid restriction was non-compliant when the facility 700-701, documents adverse/toxic reaction rapid withdrawal markets.	#22's clinical record revealed of low sodium but did not zures. The most recent elete metabolic panel) (a test wn sodium levels) (2) prior to as on 7/6/18. There was no MP was drawn. Staff could lt. Further review of Resident revealed that Resident #22 ons for his hyponatremia and with these restrictions.  It's Drug Guide for Nurses p. is the following under ons for Ativan: "Abrupt or too by result in pronounced ity, insomnia, hand tremor,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING		(X3) DAT COM	E SURVEY IPLETED
	495330	B. WING				C
NAME OF PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CO	I	04)	16/2019
GREENBRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHY CHESAPEAKE, VA 23323		RTH	
PRÉFIX (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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
Further review of th Resident #22 return with the following chospital: "Ativan 2 nevery (8) hours PRMA physician's note of Resident #22's trans 12/11/17.  On 4/11/19 at 3:51 pronducted with a flor Practical Nurse) #1. she were to administ medication cart, LPI not available in the richeck the PIXIS (ST there. LPN #1 stated called to receive a conform the PIXIS. LPN still needed for Ativate LPN #1 stated that in prescription from the to send that to pharmout Ativan from PIXI situation, she would physician to obtain a conducted with OSM pharmacy director. What was going on will 12/17 through 12/17 pharmacy had sent to needed a new script needed a new script in the prescription from the total transfer in the send that to pharmout Ativan from PIXI situation, she would physician to obtain a conducted with OSM pharmacy director. What was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician to send the send that was going on will physician the send that was going on will physician the send that was going the send that was going the send that was going the send that was going the send that was going the send that was going the send that was going the send that was going the send that was going the send that was going the send that was going the send that was going	g, muscle cramps, diaphoresis g), vomiting and seizures."  e clinical record revealed that sed to the facility on 12/15/17 manged order from the right of the facility on 12/15/17 manged order from the right of the facility on 12/15/17 manged order from the right of the facility of the	F 6				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1		LE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495330	B. WING				C /1 <b>6/2019</b>
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	10/2019
GREEN	BRIER REGIONAL ME	DICAL CENTER		1	1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	12/10/17 at 8:59 p.r night run for pharma 8:30 p.m. and that t away from the facili pharmacy could not script. When asked OSM #1 stated that OSM #1 stated that the MD to get a new mg, 4 tabs to equal sent over.  On 4/12/19 at 9:26 a conducted with LPN documented on most #22's Ativan was no process if she were wasn't available on	m. OSM #1 stated that the acy usually leaves around he pharmacy was two hours by. OSM #1 stated that it send narcotics without a hard if Ativan was in the STAT box, Ativan 0.5 mg was in PIXIS. facility staff could have called y one time order for Ativan 0.5 the 2 mg after a script was a.m., an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.m., and an interview was a.m	F6	i84			
	stated that she would pharmacy states that she would call the pa script to pharmacy could also ask the periodication for the tis STAT box. When as STAT box, LPN #2 states that the periodication for the tis STAT box, LPN #2 states that the periodical per	d contact pharmacy and if at she needs a hard script, hysician and ask him to send at LPN #2 stated that she hysician for an alternative me being that is in the facility ked if Ativan was in the facility stated that she was not sure ever had to go into the STAT she would call the physician a script, LPN #2 stated that e she shift ended and that would pass onto the next shift uld be a delay in treatment. gative outcomes for a five consecutive doses of at that the resident could go eve an increase in behaviors.					

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GREENBRIER REGIONAL MEDICAL CENTER  1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323	RIER REGIONAL M	GREENB	BRIER REGIONAL ME	DICAL CENTER			AY NUI	HIH	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC DATE DEFICIENCY)  (X5) COMPLETIC DATE  CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(EACH DEFICIEN	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
not remember. LPN #2 stated, "It probably wasn't there and I notified pharmacy, Maybe it needed a hard script or maybe it was on its way. I think we need to have our pharmacy closer." When asked if she was working the day Resident #22 went into a seizure, LPN #2 stated that she was not on shift that morning. LPN #2 could not recall what had happened to his Ativan, LPN #2 stated there should have been a nursing note. When asked of you could get Ativan from the PIXIS system without a had script, LPN #2 stated that you could not get narcotics from PIXIS if a hard script is needed. When asked if pharmacy will put a pink slip around the medication needs a new script, LPN #2 stated that pharmacy will put a pink slip around the medication card alerting staff that the prescription needs to be filled for the next time the narcotic is ordered.  On 4/12/19 at 9:33 a.m., further interview was conducted with OSM #1. When asked any negative outcomes for a resident wisn glavian long term could have withdrawal symptoms. When asked if this could lead to seizures OSM #1 stated that a resident using Alivan long term could have withdrawal symptoms. When asked if this could lead to seizures OSM #1 stated that a resident using Alivan long term could have withdrawal symptoms. When asked if this could lead to seizures OSM #1 stated that a rakivan medication and it was not in the medication cart, ASM #2 stated that she would notify the Medical Doctor for a script and call pharmacy to get a code from the STAT box. ASM #2 stated that if Alivan is not in the PIXIS, she would notify the MD for alternative orders.	not remember. LP there and I notified hard script or may need to have our plants as exercised as a seizure, LPI shift that morning. It is hould have been to use the could get Ativated that pharmathe medication can be exception needs the narcotic is orded. When a secription needs the narcotic is orded to the narcotic is		not remember. LPN there and I notified hard script or maybe need to have our phif she was working to into a seizure, LPN shift that morning. I had happened to his should have been a you could get Ativar without a had script, could not get narcot is needed. When as facility if a medication stated that pharmach the medication card prescription needs to the narcotic is order.  On 4/12/19 at 9:33 a conducted with OSN negative outcomes to stops Ativan and mis OSM #1 stated that term could have with asked if this could lestated, "It could, pot percent."  On 4/12/19 at 9:57 a conducted with ASM member) #2, the AD Nursing). When ask were to pull an Ativathe medication cart, would notify the Medicall pharmacy to get ASM #2 stated that it	I #2 stated, "It probably wasn't pharmacy. Maybe it needed a e it was on its way. I think we harmacy closer." When asked the day Resident #22 went #2 stated that she was not on LPN #2 could not recall what is Ativan. LPN #2 stated there is nursing note. When asked of in from the PIXIS system, LPN #2 stated that you tics from PIXIS if a hard script is sked if pharmacy notifies the on needs a new script, LPN #2 by will put a pink slip around alerting staff that the red.  a.m., further interview was if in a resident who abruptly isses 5 consecutive doses, a resident who abruptly isses 5 consecutive doses, a resident using Ativan long indrawal symptoms. When ead to seizures OSM #1 entially yes. I couldn't say 100  a.m., an interview was if (administrative staff bon (Assistant Director of itsed the process if her nurses in medication and it was not in ASM #2 stated that she dical Doctor for a script and its a code from the STAT box. If Ativan is not in the PIXIS,	F6				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY MPLETED
		495330	B. WING			i	C <b>16/2019</b>
NAME OF	PROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2019
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	ASM #2 stated she notes regarding the was unavailable and medication. When a negative outcomes stops taking Ativan doses, ASM #2 stat have withdrawal syr recall what had hap Ativan. ASM #2 look and confirmed that Ativan. ASM #2 stat having a hard time go physician or medical should have notified DON and/or administractions. On 4/12/19 at 12:46 conducted with ASM Resident #22's physhe was at the facility two day was at the facility or that on the days he	would expect to see nursing reasons why the medication of the steps taken to obtain the asked if there were any for a resident who abruptly and misses 5 consecutive ed that the resident could aptoms. ASM #2 could not pened with Resident #22's ked at Resident #22's MAR he had missed 5 doses of ed that if the nurse was getting in touch with the I director for a script, she I administration (herself, the	F6	i84			
	rounds in the facility was a medical profethe week except the process if a resident narcotic, ASM #3 staphysicians/NPs can the facility and if the can call his office. A until the weekend, the script until Monday, should ensure the reenough medication to	ASM #3 stated that there assional present every day of weekends. When asked the needs a script filled for a sted that he and the other write a prescription while at y are not there, the nurses SM #3 stated that if staff wait ney will not be able to get a ASM #3 stated that nurses esident has the medication or to last over the weekend.					

STATEMENT AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER		<u> </u>	- 5	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	16/2019
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	pharmacies will not narcotic. When ask outcomes for a resic consecutive doses of some people will has stated that the resid withdrawal, which constated that adverse long the resident was Resident #22 had be prior to December 2 had.  On 4/12/19 at 1:32 padministrator and A aware of the concern Resident #22's missic contributed to his see hospitalization on 12 on 4/16/19 ASM #4 physician note (ASM the survey) The following the survey of the concern anxiety-Comorbid contributed to the survey of the surve	take a verbal order for a ed the potential negative dent who misses 5 of Ativan, ASM #3 stated that ave increased anxiety. ASM #3 lent could also go into ould be more violent. ASM #3 effects depended on how as on Ativan. When asked if een on Ativan a long time 2017, ASM #3 stated that he co.m., ASM #1, the SM #4, the DON were made in for potential harm related to see doses of Ativan that elizures and lead to his 2/11/17.  presented a copy of a M #3) dated 4/15/19 (during	Fe	684			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION ING	(X3) C	DATE SURVEY COMPLETED
		495330	B. WING			C 0 <b>4/16/2019</b>
1	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COD. 1017 GEORGE WASHINGTON HIGHWA CHESAPEAKE, VA 23323		<i>1</i> 4/10/2019
(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  X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 684	say with certainty we seizure, the following to Ativan withdrawal withdrawal withdrawal prior to a tremors, sweating, less than 120 is assincreased risk of seizurned to normal was controlled. Bertake significantly lon normal. 4-pt was disneeded) ativan not not the standard practice. According to The N. "Abrupt termination accompanied by with Symptoms reported benzodiazepines intension, depression confusion, irritability phenomena, dysphodepersonalization, humbness/tingling to light, noise, and probable to light	nough it is almost impossible to that was the etiology of his and makes it unlikely to be due and the individual of the impossible to the individual of the	F 6	84		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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NAME OF	PROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	04/	16/2019	
GREENE	BRIER REGIONAL ME	DICAL CENTER		10	017 GEORGE WASHINGTON HIGHWAY NO. CHESAPEAKE, VA 23323	RTH		
(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-REFERENCEO TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 684	physician order sum Zoloft 25 MG. (antidepression. His ord "**Do Not Give with Further review of Remark (milligrams) and Zoloday. Zoloft was doctadministered daily a *Ativan (benzodiaze management of anx short-term relief of t	nmary revealed that he was on epressant) daily for er documented the following: Ativan.**** esident #22's December 2017 he was receiving Ativan 2 MG loft 25 MG (milligrams) every umented as being	F 6	84				
	(1) This information National Institutes of https://dailymed.nlm m?setid=ba6ce50e- 0e (2) This information National Institutes of https://aidsinfo.nih.g	was obtained from the f Healthnih.gov/dailymed/drugInfo.cf c5a9-47ca-9803-a1ed82172b		da da da da da da da da da da da da da d				
F 686	(3) This information National Institutes of https://dailymed.nlm m?setid=89057c93-i 4c. Complaint Deficience	was obtained from the f Healthnih.gov/dailymed/drugInfo.cf 8155-4040-acec-64e877bd2b y. trevent/Heal Pressure Ulcer	F 68	36				
		and the second s						

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION  G	(X3) DATI COM	SURVE	Y
		495330	B. WING _		1	) 	_
NAME OF	PROVIDER OR SUPPLIER				04/	6/2019	9
				STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	нін		
(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) COMPLE DATE	TION
	resident, the facility (i) A resident receive professional standa pressure ulcers and ulcers unless the ind demonstrates that the (ii) A resident with professional start promote healing, promot	egrity sure ulcers. rehensive assessment of a must ensure that- es care, consistent with rds of practice, to prevent does not develop pressure dividual's clinical condition ney were unavoidable; and ressure ulcers receives t and services, consistent andards of practice, to event infection and prevent reloping. IT is not met as evidenced int investigation, clinical y document review and staff y staff failed to ensure timely the care of multiple pressure of for 1 of 44 residents in the dent #106.  In the obtain physician orders and to obtain physician orders and to obtain physician orders and the sacral region,	F 68	F 686 Treatments to Prevent/Hea Ulcers was reviewed  1. Resident # 106 no longer facility.  2. Review of last 12 months wound orders Was conducted on Review of the last 12 mon Admit/Readmit Screener for complete assumeasurements were conducted on 5/6/20.  3. The Regional Nurse consult will provide training to the Wound nurses, Lice on Wound care management to include Wassessment upon admission within 24 hours equarterly and with decline in condition Wassessment is accurately and thoroughly for all wounds.	resides in of Admit 5/6/20 this of essment 19. tant/ Done Nur ound/slood admit found y complete y complete for admit found the y complete for admits found the y complete for admits found the y complete for admits for admits for admits for admits found the y complete for admits for admi	n the ssion  19.  and  ON ses ssion	5/31
	assessment was an Assessment Referer	imum Data Set (MDS) Admission 5/Day with an once Date (ARD) of 6/25/18. Or Mental Status was a 15		Obtaining physician orders of wounds and skin concerns upon admission and		ges.	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495330	B. WING			l	С
NAME OF	PROVIDER OR SUPPLIER	L 433330	D. WING		_	04/	16/2019
1	BRIER REGIONAL ME	DICAL CENTER		STREET ADDRESS, CITY, STA 1017 GEORGE WASHINGTO CHESAPEAKE, VA 2332	ON HIGHWAY NO	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD TO THE APPROPE CIENCY)	BE	(X5) COMPLETION DATE
	out of a possible 15 cognitively intact an making. Under Sec Resident #106 was Stage III, and 2 Stagupon admission.  Resident #106's Add dated 6/18/18 were physician orders obtreatments  Resident #106's Add 6/19/19 was reviewed as follows:  Section C 10. Skin Integrity Site: 53) Sacrum Ty Site: 25) Right Troch Stage: III* Site: 26) Left Troch Stage: III* There were no meast the pressure areas of assessment.  Resident #106's Product and are documented for the care of do room and call bell sy understanding. Order	indicating Resident #106 was d capable of daily decision tion "M" Skin Conditions, coded to have 2 Stage II, 4 ge IV pressure areas present mission Physician Orders reviewed and there were no tained for any pressure ulcer mit/Readmit Screener dated and is documented in part, pe: Pressure Stage: II* hanter (hip) Type: Pressure anter (hip) Type: Pressure surements or description of documented in the gress Notes were reviewed in part, as follows:  PM) Admission Summary: stretcher from (name) dmitted to room (number) ctor. Resident oriented to retem and voiced ers previously verified with	F 6	586	rare / Physicial that the level and ards for Li y the DON/AE ocumented at r's office.  Ing and audits the by The or compliance is	el and cense DON nd will be	
	NP (Nurse Practition 6/20/18 23:14 (11:14	PM) Skin/Wound Note: At				***************************************	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495330	B. WING			L	C <b>/16/2019</b>	
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	DICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAY NORTH  CHESAPEAKE, VA 23323				
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	approximately 1600 Nursing Assistant) a nurse to the room to resident. Resident and therefore soiled dressings were app orders were reviewed dressings and ointer resident's chart, no orders were put in a assessment on 6/19 care and treatments  Resident #106's Phy were reviewed and follows:  1. Calcium Alginate every day shift for w wound cleanse, app dressing daily and a 2. Calcium Alginate every day shift for w with wound cleanse, dry dressing daily ar  3. Dakins Solution A every day shift for w wound cleanse, app dry dressing daily ar  On 4/16/18 at 10:26 conducted with the I Resident #106's adn of Nursing was aske wound care orders a Resident #106's sac Resident #106's sac	(4 PM) the CNA ( Certified assigned to resident called this assigned to resident called this apply new dressings on has been having loose stools applied dressings. New lied temporarily until treatment ed to see what the proper ments are. Upon reviewing documentation or treatment at that time. Wound nurse did 9/18. Will follow up on proper seneded for resident.  Spician Orders dated 6/20/18 are documented in part, as a Apply to left hip topically ound care, clean left hip with all Calcium Alginate and dry seneded.  Apply to right hip topically ound care, clean right hip apply Calcium Alginate and and as needed.  Apply to sacrum topically ound care, clean sacrum with ly dakins soaked gauze and	F	386				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY MPLETED
		495330	B. WING	·			C <b>16/2019</b>
	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		10/2010
(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 APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	orders on admission ulcer and we should responsible to make care for the residen. The facility policy titt Orders" revised 9/2d documented in part. Policy Statement: Fappropriate admission. Outcomes:  1. Residents/patient treatments and serve. Residents and paccomplications becaute or delayed admission. The facility's care related standards are laws and regulations. Procedure:  1. The attending phadmission and read his/her knowledge of a review by facility service by facility services. Admission and redications, treatment of the facility of the facilit	s, we did fail to obtain the for the resident's pressure have obtained them. We are esure we have a continuity of the from the hospital."  Ided "Admission/Readmission 017 was reviewed and is as follows:  Physicians shall provide on and readmission orders.  Its will receive appropriate prices upon admission orders.  Its will receive appropriate prices upon admission.  In attents will not suffer use of incomplete, inaccurate, in orders.  Its will be consistent with a will comply with applicable of the resident/patient and on the following price of the resident/patient and on the surface of the resident/patient and on the surface of the resident/patient and on the surface of the resident/patient and on the surface of the resident/patient and on the surface of the resident/patient and on the surface of the resident/patient and on the surface of the resident/patient and on the surface of the resident/patient and on the surface of the surface of the resident/patient and on the surface of	F	386			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING			E SURVEY APLETED
		495330	B. WING			1	C
NAME OF	PROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP	CODE	<u>  U4/</u>	16/2019
GREEN	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGH CHESAPEAKE, VA 23323	HWAY NO	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 686	This is a Complaint  *The National Press (NPUAP.org) descr  Stage 2 Pressure Ir loss with exposed of Partial-thickness los dermis. The wound moist, and may also ruptured serum-fille visible and deeper t Granulation tissue, present. These injuit adverse microclimat the pelvis and shear should not be used associated skin dan incontinence associ intertriginous dermat related skin injury (N (skin tears, burns, a)  Stage 3 Pressure In Full-thickness loss of is visible in the ulcer epibole (rolled wound Slough and/or escha of tissue damage val areas of significant as	Deficiency.  Sure Ulcer Advisory Panel iptions:  Diury: Partial-thickness skin ermis as of skin with exposed bed is viable, pink or red, or present as an intact or diblister. Adipose (fat) is not issues are not visible.  Slough and eschar are not ries commonly result from the and shear in the skin over rin the heel. This stage to describe moisture mage (MASD) including atted dermatitis (IAD), titis (ITD), medical adhesive MARSI), or traumatic wounds	F6	•			
	Fascia, muscle, tend and/or bone are not	don, ligament, cartilage exposed. If slough or eschar of tissue loss this is an re Injury	F 68	87		manum magas agree special estado estado estado estado estado estado estado estado estado estado estado estado e	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495330	B. WING			ì	C 16/2019		
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	04)	10/2013		
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323				
(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 DATE		
F 687	Continued From pa	ne 117	F 68	207	F 687 Foot care	•	5/31		
	§483.25(b)(2) Foot	care.	ro	187	1. Resident # 24 Received her d	ishetic	2019		
	To ensure that resid	ents receive proper treatment nobility and good foot			shoes on 1/19/2019.	,	•		
	health, the facility must:  (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and  (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.  This REQUIREMENT is not met as evidenced by:				. The Medical Director was not	tified			
					of the date of receipt.				
					Resident # 17 diabetic Physic	ian			
					orders dated and stamped				
					Was re-submitted to the Orth	10-			
					clinic due to resident having				
					Amputated toes to the right f	oot.			
	Based on a compla	int investigation, facility			On 5/9/2018 and appointmer	nt has			
		interviews, resident interviews at review the facility staff failed			been set by the Orthotics				
	ensure 2 of 44 resid	ents in the survey sample			And prosthetics clinic for spec		•		
	received their diabel Resident #17 and R	ic shoes in a timely manner, esident #24.			diabetic shoes due to amputa	ted			
	4 774 - 410				Toes.				
	diabetic shoes was p	ailed to ensure a pair of provided to Resident #24 in a			2. Beginning on 5/3/2019 a Revie	ew of			
	timely manner.				Diabetic resident Physician				
	2. The facility staff f	ailed to provide Resident #17			Orders, Podiatry and wound o	rders			
3	with physician order	red diabetic shoes.			were reviewed for any foot				
	The findings include	d:			care orders, to include diabet	ic			
***************************************	Resident #24 was	s a 76 year old admitted to			shoes was conducted by the	1			
ļ	the facility on 1/11/18	3 with diagnoses to include		-	Regional Nurse consultant.		distribution of the state of th		
	but not limited to Typ Peripheral Vascular I	e 2 Diabetes Mellitus and Disease.				Peri Turkahi Princia			
				-	Review of Physician orders to	and deleter that an			
	The most recent Minimum Data Set was an Annual assessment with an Assessment				include podiatrists and wound				
	Reference Date of 1	with an Assessment 21/19. The Brief Interview			care will be reviewed 5x week	1	[		
		s a 12 out of a possible 15			clinical start-up by the DON/A	OON.	ļ		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495330	B. WING			04/	16/2019
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			017 GEORGE WASHINGTON HIGHWAY NO	RTH	
	,···			С	CHESAPEAKE, VA 23323		
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					3. The Regional Nurse consultan	t/DON	
F 687			Fe	87	will provide training to		
	indicating Resident capable of daily dec	#24 was cognitively intact and			License nurses and social serv	vices	
	•	ū			on Timely review of physician		
	Resident #24's Tele	phone Physician Order dated			Orders for ordering Diabetic s	hoes,	
	3/7/18 was reviewed and is documented in part, as follows:				appropriate paperwork to		
	do 10110110.				completed to include the phy-	sician	
j	3/7/18; Diabetic Shoes (Name) Shoes with				orders to the provider and		
	phone number listed	j.			to follow-up on progress of the	2	
	On 4/15/19 at 10:15	A.M. an interview was			delivery of the shoes to		
conducted with Resident #24 about her diabetic				ensure timely delivery.			
ĺ	shoes. Resident #2	4 pointed to a pair of shoes		1	Inservice/training began on		
	"There they are it to	head of her bed and stated, ook forever but I finally got			5/3/2019.		
	then. It took a long	time to get them but I like		ļ	5,5,2013.		
	them."	3		/	1. Assistive device and equipmen	.	
	On 4/15/10 at 0:00 F	P.M. an interview was		_	audit to include diabetic shoes		
		Pediorthist who was the				i	
	company owner that	was called to size and order		Ì	Timely ordering and receiving o	of the	į
	Resident #24's diabe	etic shoes. The Pediorthist			shoes will be conducted by		
***************************************	stated, "We went ou	t on 3/21/18 to size her do an evaluation. Also on			DON/ADON 1x week x 4 then 1	LX	
West and a	3/21/18 we faxed ov	er the documents we needed			month x 3 then Quarterly.	ĺ	
	to be completed by t	he residents physician. We		Ī		İ	
į	re-faxed the same d	ocuments on 4/25/18,		l	The audits will be documented	and	
ĺ	7/18/18, and again o	n 12/19/18. We finally ted and signed documents		ļ	maintained		
1	from the physician or	n 1/4/19. The diabetic shoes			in the Administrator's office.		
1	were delivered to the	resident on 1/19/19. Once					
	we have obtained all	the necessary the physician it is only a 2		Ì	Results of the training and audit	is	
		ne for the shoes to arrive for			will be presented Monthly		
	the resident. The ho	ld-up for her (Resident #24's			to the QAPI committee by The		-
4107	) shoes was not us it	was the physician."			Administrator and/or		***************************************
	Documents provided	from the Pediorthist for		and the same of th	the DON to ensure compliance i	s	ĺ
	Resident #24's diabe	tic shoes were reviewed and			achieved and sustained.		

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SI AND PLAN OF CORRECTION IDENTIFICATION		1 ' '		PLE CONSTRUCTION		E SURVEY
		495330	B. WING	·		ľ	C <b>/16/2019</b>
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GALLINE	MEN NEGICIVAL WE	DICAL CENTER			CHESAPEAKE, VA 23323		
(X4) ID		TEMENT OF DEFICIENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION	Ŋ	(X5)
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F 687	Continued From pa	ge 119	Fε	887			
:	revealed the Attend 1/3/19.	ing Physician's signature on					VV management de la financia del financia del financia de la finan
	The facility policy tit Equipment" revised documented in part	led "Assistive Devices and 17/2017 was reviewed and is , as follows:					Marini kada manara indonono ya manada ada paga p
	maintains, trains an	Our facility provides, d supervises the use of nd equipment for residents.					verteinno varie un e para pre regipa de la la la la la la la la la la la la la
	resident mobility, sa	uipment that assist with Ifety and independence are Its. These include, but are not					
TO THE PROPERTY OF THE PROPERT	7. Requests or the should be referred to Department.	need for special equipment o the Social Services					AND THE PROPERTY OF THE PROPER
Andreas da	held with the Admini Nursing and the Regwere the above info Director of Nursing have expected Residiabetic shoes and i reasonable amount them. The Director should have receive provider could get the yes she should have should have followed communication with provider." The Regi	P.M. a pre-exit debriefing was istrator, the Director of gional Director of Operations rmation was shared. The was asked when would she dent #24 to have received her if ten and a half months was a of time to have to wait for of Nursing stated, "She de them as soon as the nem shipped to the facility and e had them much sooner. We d-up and had better the physician and the shoe onal Director of Operations by noted and we know that this					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONS	(X3) DATE SURVEY COMPLETED		
		495330	B. WING			i e	C 16/2019
	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		1017 GE	ADDRESS, CITY, STATE, ZIP CODE ORGE WASHINGTON HIGHWAY NO PEAKE, VA 23323	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	This is a Complaint  2. Resident #17 was 1/15/18 with diagnor cardiovascular disection diabetes, and demorprovide Resident #1 diabetic shoes.  An Annual MDS data resident as having a difficulty. Resident #1 glasses. In the area resident was assess 15 which indicated a resident has an ADI seizures. Goal: The level of function with process. Approache PRN any changes, a reasons, for self-cardeclines in function. The resident is at ris anxiety, diabetes, cardeclines in function. The resident will not through the review; that the resident is when ambulating.  A Physician order da "Resident #17 was a shoes." During an in	ed to work on."  Deficiency.  Se admitted to the facility on ses of hypertension, ase, epilepsy, anxiety, entia. The facility staff failed to 17 with physician ordered  ed 1/22/19 assessed this no hearing, or speech 17 was assessed as needing of Cognitive Patterns this sed as having a BIMS score of no cognitive impairment.  12/4/19 indicated: Focus: The self-care deficit due to resident will maintain current ain the scope of the disease es: Monitor/document/report cotential for improvement, re deficit, expected course,	F	87			

STATEMENT AND PLAN (	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495330	B. WING	à		1	C	
NAME OF	PROVIDER OR SUPPLIER	<u> </u>	J	Γ	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	/16/2019	
GREENE	BRIER REGIONAL ME	DICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323					
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SS=D	was not aware Residiabetic shoes." Du South Nurse Managknow the reason for not having diabetic. The facility staff fails with physician order Pain Management CFR(s): 483.25(k) §483.25(k) Pain Ma The facility must ensprovided to resident consistent with profethe comprehensive and the residents' garding a seed on record recomplaint investigation adequately assess a one resident (Resident 44 residents.  The findings include Resident #57 was really 19 with diagnos of sepsis due to Escesophagitis, muscle abnormalities of gait depression, diabetes	ident #17 had a order for ring an interview with the Unit ger, she stated, she did not the hold up for Resident #17 shoes.  ed to provide Resident #17 red diabetic shoes.  Inagement.  Sure that pain management is swho require such services, person-centered care plan, poals and preferences.  IT is not met as evidenced view, staff interview and a sion, the facility staff failed to and obtain pain medication for tent #57) in the survey sample d:  e-admitted to the facility on ses which included a history herichia coli (E.Coli) weakness, dysphagia, hypertension, COPD, a cardiovascular disease, contracture of left hand. The provide routine pain	F 6	69		ning y by the	5/31 2019	
	A Re-entry Minimum	Data Set (MDS) dated				***************************************		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[ ' '		E CONSTRUCTION		E SURVEY IPLETED
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NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER	l	10	D17 GEORGE WASHINGTON HIGHWAY NO	RTH	
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	2/25/19 assessed the difficulties in the area or understanding ar In the area of Cognitudes assessed for a brief (BIMS) and scored assessed in the area of assessed in the area of locomotion on unit. as requiring extensification on unit. as requiring extensification on the area of hygiene. In the area of hygiene. In the area of hygiene. In the area of rated pain in the last from 0 to 10.  A Care Plan dated 8 resident has c/o pain History of CVA, tooth resident will verbaliz ability to cope with in through the review of Administer analgesia resident's need for promediately to any of the effectiveness of compliance, alleviating schedules and residing action. Monitor/dof each pain episode possible.	nis resident as having no be a of hearing, speech, vision and the ability to be understood. It the ability to be understood. It the ability to be understood. It the ability to be understood. It the ability to be understood. It the ability to mental Status a (13). This resident was a of Activities of Daily Living a supervision and one person of the mobility, transfers, and This resident was assessed we assistance with one person of dressing and personal of Pain Management this sed as having pain within the sident was assessed as an This resident was assessed as an This resident was assessed as an This resident was assessed as an This resident was assessed as an This resident was assessed as a thin the sident was	F 6	4.	Medication Availability/Narcotic will be conducted by the DON/ADON/UM 2x week x 4 the week.  The audits will be documented armaintained in the Administrator's office.  Results of the training and audits presented Monthly to the QAPI committee by The Administrator at the DON to ensure compliance is achieved and sustained.	n 1 x nd s will be	
	•	nmary dated 7/10/18 at 33:00					

C 495330  NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323	AND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  GREENBRIER REGIONAL MEDICAL CENTER  1017 GEORGE WASHINGTON HIGHWAY NORTH			60F00D					С
GREENBRIER REGIONAL MEDICAL CENTER  1017 GEORGE WASHINGTON HIGHWAY NORTH			495330	B. WING			04/	16/2019
			DICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH				
	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	(X5) COMPLETION DATE
Continued From page 123 (12:33 A.M.) indicated: "Resident arrived via WC, accompanied by two unknown individuals and admitted to Rm. (number). Grocery bag w/bottles of medications left at nurses station. members of administration evaluated resident and determined, due to his poor condition and presentation, he was to be sent back out to ER for further evaluation. Transport arrived at approximately 18:35. Resident refused to go to hospital. Transport expressed that since resident is A & O X 3, he has the right to refuse."  A Medication Order Summary dated 7/10/18 Indicated: "The following medications: Norco Tablet 5-325 MG (Hydrocodene Acetaminophen) give 1 tablet by mouth every 4 hours as needed for PAIN.  Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) give 1 tablet by mouth every 4 hours as needed for Pain max daily amount 12 tabs.  Percocet Tablet 10-325 MG (Oxycodone-Acetaminophen) give 2 tablets by mouth every 4 hours as needed for Pain Max daily amount 12 tabs.  A Medication Manifesto signed and dated 7/11/18 indicated: the following medications were received for Resident #57.  Quantity- 30- Backofen tab 20 mg 60- Benztropine tab 0.5 mg 30 -Citalopram tab 20 mg 40 -Cephalexin cap 500 mg 30 -Glipizide tab 5 mg 30 -Alorvastatin tab 40 mg	F 697	(12:33 A.M.) indicated accompanied by two admitted to Rm. (nutering of medications left a administration evaluation administration evaluation, he was for further evaluation approximately 18:35 hospital. Transport is A & O X 3, he has a Medication Order Indicated: "The following Tablet 5-325 MG (Highway 1 tablet by mount or PAIN.  Percocet Tablet 10-3 Acetaminophen) give hours as needed for tabs.  Percocet Tablet 10-3 (Oxycodone-Acetaminophen) give hours as needed for tabs.  Percocet Tablet 10-3 (Oxycodone-Acetaminophen) give hours as needed for tabs.  A Medication Maniferindicated: the following amount 12 tabs.  A Medication Maniferindicated: the following aceived for Resider Quantity- 30- Bacloft 60- Benztrop 30 - Citalopra 40 - Cephale 30 - Glipizide	ted: "Resident arrived via WC, o unknown individuals and amber). Grocery bag w/bottles at nurses station. members of uated resident and his poor condition and is to be sent back out to ER in. Transport arrived at 5. Resident refused to go to expressed that since resident is the right to refuse."  Summary dated 7/10/18 awing medications: Norco ydrocodene Acetaminophen ) at every 4 hours as needed  325 MG (Oxycodone-re 1 tablet by mouth every 4 reain max daily amount 12  325 MG ninophen) give 2 tablets by as as needed for Pain Max is.  235 sto signed and dated 7/11/18 ing medications were not #57.  24 en tab 20 mg paine tab 0.5 mg am tab 20 mg exin cap 500 mg exin	F€	397			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	(X3) DATE SURVEY COMPLETED	
495330 B. WING	C <b>/16/2019</b>	
NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAY NORTH  CHESAPEAKE, VA 23323	110/2013	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
Continued From page 124 60- Metformin tab 500 mg 30 - Clopidogrel tab 75 mg 30 - Finasteride tab 5 mg Resident #57's pain medications were not available.  An Admission summary dated 1/28/19 at 22:36 (10:36 P.M.) indicated: "Resident arrived at 1743, on stretcher, able to make wants and needs known. No complaints of pain, Resident has a Foley 16 French. Foley is draining clear yellow urine. No dentures or hearing aides seen. clear lungs sound. weak left side of body. Dressing on the right upper on where PICC line was in place. Dry and intact, no bruises or marks on the body. No open areas. Resident has redness on the scrotum and on the sacrum area. Call bell within reach will continue to monitor."  A Orders-Administration Note dated 1/28/19 at 22:23 (10:23 P.M.) indicated: "Pharmacy called about the residents medication and stated that the insurance paid for his medication for the month and he would not be able to send all his meds. Stated that they would send some of his medication and then when the month started over they would send all the medication."  A review of the Medication Administration Record (MAR) dated January 2019 indicated: Pain level every shift for Pain start date? 7/10/18. A review of the MAR from January 28 through January 31 indicated Resident #57 was not assessed for pain nor did he receive pain medications during this time period.  During an interview on 4/16/19 at 11:15 A.M. with the Assistant Director of Nursing (ADON) she was asked if Resident #57 should have received		

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PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 697  Continued From page 125  his medications and she stated, Yes. When asked were the pain medications given to Resident #57 she stated, "No." When asked if the facility had stat meds for use, the ADON stated, "Yes." When asked why staff did not provide this resident pain meds from the stat box she stated, "she did not know."  The facility staff failed to provide pain	GREEN	BRIER REGIONAL ME	DICAL CENTER	1					
his medications and she stated, Yes. When asked were the pain medications given to Resident #57 she stated, "No." When asked if the facility had stat meds for use, the ADON stated, "Yes." When asked why staff did not provide this resident pain meds from the stat box she stated, "she did not know."  The facility staff failed to provide pain	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFI	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			(X5) COMPLETION DATE	
F 727 SS=E RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)  §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at  F 727  F 727  F 727  F 727  F 727  F 727  RN hours/ 7 days/Wk., Full Time DON 5,	F 727	his medications and asked were the pair Resident #57 she s facility had stat med "Yes." When asked resident pain meds "she did not know."  The facility staff failt medications. RN 8 Hrs/7 days/WI CFR(s): 483.35(b)(1) Excep paragraph (e) or (f) must use the service least 8 consecutive §483.35(b)(2) Excep paragraph (e) or (f) must designate a redirector of nursing of \$483.35(b)(3) The das a charge nurse of average daily occup. This REQUIREMEN by: Based on staff interdocumentation revies staff a Registered Not a day, 7 days a weel Director of Nursing (supervisor/charge nurse of a day, 7 days a weel Director of Nursing (supervisor/charge nurse) and a census of 60 control of the pair of	d she stated, Yes. When a medications given to tated, "No." When asked if the ds for use, the ADON stated, why staff did not provide this from the stat box she stated, ed to provide pain (k, Full Time DON 1)-(3)  red nurse of when waived under of this section, the facility es of a registered nurse for at hours a day, 7 days a week. Ot when waived under of this section, the facility gistered nurse to serve as the n a full time basis.  Iirector of nursing may serve nly when the facility has an ancy of 60 or fewer residents. It is not met as evidenced views and facility the facility staff failed to urse (RN) for at least 8 hours k and failed to ensure the DON) worked as a urse only when the facility or less.	F 7	7 RN hours/ 7 days/Wk., Full 1  1. The RN schedule for weeke was reviewed for the mont 2019 to ensure RN coverag Was scheduled.  The staffing coordinator recimmediate re-training on the ensure 8 hours of RN coverage.	end cov th of Ap te for 8 ceived ne proci	rerage oril hours	5/31	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495330	B. WING	·		1	C 1 <b>6/2019</b>
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	10/2019
OPERA	NIPO DEGLAVIAL ES			ŧ	017 GEORGE WASHINGTON HIGHWAY NO	RTH	
GREEN	BRIER REGIONAL ME	DICAL CENTER		CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 727	A review of the as we 2018 through April 1 resulted in further recoverage. The review RN coverage for at and the DON worken urse when the faci 60 residents on the 1. Sunday, October called out, there was was on orientation. a.m3.15 p.m.).  2. Saturday, October Nursing (DON) worked p.m.) with a facility of 3. Sunday, October Nursing (DON) worked (DON) w	vork schedules from October 14, 2019, were reviewed which eview of the RN weekend ew concluded there was no least 8 consecutive hours of as a supervisor/charge lity had a census of more than following days:  7, 2018, the scheduled RN is a RN in the facility but she She worked 5.5 hours (9:45)  or 20, 2018, the Director of ited as the supervisor/charge 5.5 hours (10:45 a.m4:15 census of 108.  21, 2018, the Director of ited as the supervisor/charge 7.25 hours (8:15 a.m3:30)	F7	2.	coverage for the month of April immediately notified on 4/14/20 the requirements of 8 hours.  7 days a week review of RN staffhours will be conducted by the coordinator and Administrator. began on 4/16/2019	was 019 of fing staffing This ed Staffing y the	
	7.5 hours (7:02 a.m. 5. Saturday, January worked 7.75 hours (6. Sunday, March 17.75 hours (6.57 a.m. 7. Saturday, March worked 4.75 hours (7.	7 19, 2019, the RN only 6:59 a.m 3-15 p.m.). 7, 2019, the RN only worked 1 3:22 p.m.). 23, 2019, the RN only 7:02 a.m 11:40 a.m.).		WANTED THE PROPERTY OF THE PRO	On 5/2/2019 The DON received conducted by the Regional Direct Clinical Operation on when the Lof Nursing may serve as a charge and the average daily occupancy requirements.	ctor of Director	_
		23, 2019, the Director of ed as the supervisor/charge		- Augusta			

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495330	B. WING_		С				
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	04/16/	2019			
				1017 GEORGE WASHINGTON HIGHWAY NO					
GREEN	BRIER REGIONAL ME	DICAL CENTER		CHESAPEAKE, VA 23323					
(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 APPROPR DEFICIENCY)	BE CO	(XS) OMPLETION DATE			
F 727	Continued From pa	ge 127	F 72	7					
	nurse. The DON di nurse on 03/23/19 (	d a split shift with another a.m3:30 p.m. shift). The 11:14 a.m4:24 p.m.) with a							
	facility census of 10	3.	4.	Registered Nurse staff hours audit	will				
	O Catuada A all O	0.0040.11.151		be conducted by the DON/					
	9. Saturday, April 06, 2019, the Director of Nursing (DON) worked as the supervisor/charge nurse. She worked 9.5 hours (7:28 a.m 5:08 p.m.) with a facility census of 106.			Administrator 1x week					
	p.m.) with a facility of	census of 106.							
	10. Saturday, April 13, 2019, the RN only worked 7.75 hours (7:00 a.m3:15 p.m.).			maintained in the Administrator's o	office.				
				Results of the training and audits w	rill be				
	A phone interview w	as conducted with the on 04/12/19 at approximately	presented Monthly to the QAPI						
	10:15 a.m. She said	she does not work on		nd/or					
	weekend so if some	one calls out, the nursing		the DON to ensure compliance is	.				
	staff will call the nur	se on call to provide the		achieved and sustained.					
	necessary RN cover Coordinator stated.	The nurses know they		***					
	should be working 8	hours when they are							
	providing RN covera	ige on the weekends."							
	A briefing was condu	ucted via phone with the							
-	Administrator and In	terim Director of Nursing			İ				
	(IDON) on 04/12/19	at approximately 4:55 p.m.							
	No other information	was provided.			-				
	A phone interview wa	as conducted with the IDON			non-sales and sa				
	on 04/15/19 at appro	oximately 11:45 a.m. The			Ì				
	IDON stated, "The D	ON can only work as a							
	census of 60 or less	ervisor when the facility has a " She also said the RN			ļ				
		overage must work at least 8				•			
F 755		cedures/Pharmacist/Records ()(1)-(3)	F 755						
		·							
		i i			1				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		495330	B. WING			C 16/2019		
NAME OF	PROVIDER OR SUPPLIER		<u>'                                      </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-41	10/2013		
GREENE	BRIER REGIONAL ME	DICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323					
(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)	(X5) COMPLETION DATE			
F 755	,	-	F 75	5		·		
	§483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-			55 Pharmacy Srvcs/ Procedures, narmacist/ Records  1. Resident #57 narcotic count w completed on 4/12/2019 for availability, reorder needs and adequate supply. Resident #5 medication administration rec reviewed for the month of Apr Resident #57 MD was notified omission of resident pain med 7/11/2018 and 1/28/2019	as 7 ord was il. of the ication c			
The second secon	the facility.  §483.45(b)(2) Estab receipt and disposition sufficient detail to enreconciliation; and §483.45(b)(3) Determined and that an action is maintained and performance in the REQUIREMEN by:  Based on record recomplaint investigation in the second	lishes a system of records of on of all controlled drugs in table an accurate mines that drug records are in count of all controlled drugs eriodically reconciled. To is not met as evidenced view, staff interview and a on, the facility staff failed to medication to one resident e survey sample of 44	3.	<ol> <li>All residents have the potential affected.</li> <li>On 5/3/2019 License nurse training began on Medication Availability MD notification by the Regional Inconsultant/DON.</li> </ol>	ng and			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	
		495330	B. WING	<b>.</b>	, <del></del>	I	С
ļ	PROVIDER OR SUPPLIER BRIER REGIONAL ME	<u> </u>		S1	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		/16/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED (CROSS-REFERENCE)	8E	(X5) COMPLETION DATE
F 755	Resident #57 was r 1/28/19 with diagnor of sepsis due to Estesophagitis, muscle abnormalities of gardepression, diabete hyperlipidemia, and facility staff failed to medications available.  A Re-entry Minimum 2/25/19 assessed the difficulties in the area of cognical assessed for a brief (BIMS) and scored assessed for a brief (BIMS) and scored assessed in the area of locomotion on unit, as requiring extensiset-up in the area of locomotion on unit, as requiring extensiset-up in the area of hygiene. In the area of hygiene. In the area of hygiene, In the area of hygiene, In the area of hygiene, In the area of resident was assessed as to 5 days. This resident was assessed for a brief of the area of resident has assessed for a brief of the area of hygiene. In the area of hygiene, In the area of resident has copain in the last from 0 to 10.  A Care Plan dated 8 resident has copain History of CVA, tooth resident will verbalize the sident will verbal	e-admitted to the facility on ses which included a history cherichia coli (E.Coli) weakness, dysphagia, it, hypertension, COPD, is, cardiovascular disease, contractures of left hand. The	F	755	Medication Availability/Narcotic will be conducted by the DON/ADON/UM 2x week x 4 the week.  The audits will be documented a maintained in the Administrator office.  Results of the training and audits presented Monthly to the QAPI committee by The Administrator the DON to ensure compliance is achieved and sustained.	n 1 x nd 's will be and/or	

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		TE SURVEY MPLETED
		495330	B. WING				С
NAMEOE	PROVIDER OR SUPPLIER	1 403000	0. 11110	_		04/	/16/2019
TANAL OF	I NOVIDEN ON SUFFEIER	•			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 755		~	F7	'55	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	through the review	date. Approaches/Tasks -					
	Administer analgesi	ia as per orders. Anticipate the					4
	resident's need for p	pain relief and respond					
	Immediately to any	complaint of pain. Evaluate					
	compliance alleviat	pain interventions. Review for ion of symptoms, dosing					
	schedules and resid	dent satisfaction with results,					
	impact on functiona	l ability and impact on					
	cognition. Monitor /c	document for probable cause					
		e. Remove/limit causes where					<b>[</b>
	possible.	***************************************					
	A Do-admicsion Cu	mmary dated 7/10/18 at 33:00					-
	(12:33 A.M.) indicate	ed: "Resident arrived via WC,					
	accompanied by two	unknown individuals and					
	admitted to Rm. (nu	mber). Grocery bag w/bottles					
	of medications left a	at nurses station. members of					
	administration evalu						
	determined, due to I	his poor condition and					
	for further ovaluation	s to be sent back out to ER n. Transport arrived at					
	approximately 18:35	5. Resident refused to go to					
		expressed that since resident					Control of the Contro
		s the right to refuse."					
	A Medication Order	Summary dated 7/10/18					
	Indicated: "The follo	wing medications: Norco					
		ydrocodene Acetaminophen )					
1	give 1 tablet by mou	th every 4 hours as needed		į			
ľ	for PAIN.						
	Percocet Tablet 10-9	325 MG (Oxycodone-					
	Acetaminophen) giv	e 1 tablet by mouth every 4					
		Pain max daily amount 12					
	tabs.			Ì			
	Percocet Tablet 10-3	325 MG					
		ninophen) give 2 tablets by					
		as needed for Pain Max					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		LE CONSTRUCTION	(X3) DAT COM	E SURVEY
		495330	B. WING			Ī	C <b>16/2019</b>
NAME OF	PROVIDER OR SUPPLIER	100			STREET ADDRESS, CITY, STATE, ZIP CODE	0-47	10/2019
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NOI CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	ļ	<b>-</b>	F 7	'55			
	daily amount 12 tab	s.					
	A Medication Manife indicated: the follow received for Reside	esto signed and dated 7/11/18 ing medications were nt #57.					
	30 -Citalopr 40 -Cephale 30 -Glipizide 30 -Atorvas 30 -Lisinopr 60- Metform 30 -Clopido 30 -Finaster	pine tab 0.5 mg am tab 20 mg exin cap 500 mg					
	(10:36 P.M.) indicate on stretcher, able to known. No complair Foley 16 French. Fourine. No dentures of lungs sound, weak I the right upper on w Dry and intact, no be No open areas. Resscrotum and on the reach will continue to A Orders-Administrate 22:23 (10:23 P.M.) is about the residents of the insurance paid for month and he would	nary dated 1/28/19 at 22:36 ed: "Resident arrived at 1743, make wants and needs ats of pain, Resident has a aley is draining clear yellow or hearing aides seen. clear eft side of body. Dressing on here PICC line was in place. ruises or marks on the body. ident has redness on the sacrum area. Call bell within or monitor."  Ition Note dated 1/28/19 at andicated: "Pharmacy called medication and stated that or his medication for the not be able to send all his ey would send some of his					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '		LE CONSTRUCTION		E SURVEY IPLETED
		495330	B. WING	i		I	C <b>16/2019</b>
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	10/2019
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
	they would send all  During an interview the Assistant Direct was asked if Reside his medications and asked were the pair Resident #57 she si  A facility Policy on F Oversight: Policy St help the facility monbiologicals as well a services.  Procedure: B Safe distribution, use and biologicals.  The facility staff falle services were provided Laboratory Services CFR(s): 483.50(a)(1) The falaboratory services tresidents. The facility proviservices, the services services, the services.	on 4/16/19 at 11:15 A.M. with or of Nursing (ADON) she ent #57 should have received if she stated, Yes. When in medications given to tated, "No."  Pharmacy and Therapeutics atement - Physicians shall aitor its use of medications and its the quality of its pharmacy in procurement, storage, if disposal of drugs and ded to acquire medications is accility must provide or obtain to meet the needs of its by is responsible for the quality its eservices.	F 7	755	DEFICIENCY)		
27.7	of this chapter. This REQUIREMEN by: Based on clinical re and review of the fac	oratories specified in part 493  IT is not met as evidenced ecord review, staff interviews, cility's policy the facility staff eeds of the residents by					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION		E SURVEY PLETED
		495330	B. WING	i		ł	С
NAME OF	PROVIDER OR SUPPLIER	10000	1			04/	16/2019
	RIER REGIONAL ME	DICAL CENTER		11	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NOI CHESAPEAKE, VA 23323	RTH	
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 770	Continued From pa		F 7	770			5/31
	collecting specimen services for 1 of 44 the survey sample.	s and obtain laboratory residents (Resident #51), in			F 770 Laboratory Services		2019
	The facility staff fails monthly complete be and the facility staff metabolic panel, thy hemoglobin A1C leverand a lipid profile or December beginning. The findings include Resident #51 was on 6/29/15 and the residischarged from the diagnoses include; sinsufficiency and another the diagnoses include; sinsufficiency and another the diagnoses include; sinsufficiency and another the diagnoses include; sinsufficiency and another the diagnoses include; sinsufficiency and another the diagnoses include; sinsufficiency and another the diagnoses include; sinsufficiency and scoring indicates Resident #daily decision makin (Physical functioning requiring supervision locomotion, dressing assistance of one with hygiene, extensive a with bed mobility, training supervision with the diagnoses includes the dia	riginally admitted to the facility dent has never been facility. The current stroke with hemiparesis, renal emia.  um Data Set (MDS) assessment reference date ded the resident as Interview for Mental Status 13 out of a possible 15. This 151's cognitive abilities for g were intact. In section "G" by the resident was coded as a after set-up with off unit g and eating, limited ith toileting and personal issistance of one with person insfers, and bathing.			the Unit manager/ADON 1x we weeks then 1x month.  The audits will be documented maintained in the Administrator	tted lab 2018, 8, and 2019 actition o be 019. I of any cations ining ining of ucted b ek x 4	er e
	summary revealed o monthly complete blo metabolic panel, thy	2019, physician order orders dated 6/4/18, for a cood count, and complete roid stimulating hormone, els, magnesium, uric acid,		*******	Results of the training and audit presented Monthly to the QAPI committee by The Administrato		

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT COM	E SURVEY MPLETED
		495330	B. WING				C <b>16/2019</b>
NAME OF	PROVIDER OR SUPPLIER		1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	10/2019
					1017 GEORGE WASHINGTON HIGHWAY NO	RTH	
GREEN	BRIER REGIONAL ME	DICAL CENTER			CHESAPEAKE, VA 23323		
(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 APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE
F 770	and lipid profile order December. Review revealed monthly conditioned 7/2018, 8/ and 4/2019, therefor 10/18, 12/18 and 3/ complete metabolic hormone, hemogloburic acid, and lipid profile August 2018, December 2019.  An interview was conditioned a list of a obtained since 6/4/1 above, many labs with stated the orders we should have been diphysician had given number of labs order the above findings. Administrator, Director Corporate Consultant approximately 1:40 stated the orders had orders were obtained. The facility's policy to Results-Clinical Prophysician will identifit testing based on dianeeds. The staff will arrange for test. The	ered every April, August and of the laboratory reports emplete blood counts were 2018, 11/2018, 1/2019, 2/2019 re monthly labs for 9/18, 19 were not obtained. The panel, thyroid stimulating bin A1C levels, magnesium, profile levels were not obtained ember 2018 or scheduled for enducted with the Assistant 4/11/19, at approximately 4:45 Director of Nursing stated she is clinical record and ll labs the resident had ll. The audit revealed as ere not obtained. She also ere active but some of them iscontinued therefore; the new orders reducing the ered.  Were shared with the tor of Nursing and the nt on 4/16/19 at p.m. The Director of Nursing and been reviewed and new d.  itled "Lab and Diagnostic Test tocol" dated 9/2012 read; the y and order diagnostic and lab ignostic and monitoring process test requisitions, and a laboratory, diagnostic or other testing source will	F 7	770	the DON to ensure compliance achieved and sustained.	is	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DAT	E SURVEY IPLETED	
		495330	B. WING			ļ	C 16/2010
NAME OF I	PROVIDER OR SUPPLIER	L	<u> </u>	ST	FREET ADDRESS, CITY, STATE, ZIP CODE	<u>U47</u>	16/2019
		•	1		117 GEORGE WASHINGTON HIGHWAY NO	טדט	
GREENB	BRIER REGIONAL ME	DICAL CENTER		ŀ	HESAPEAKE, VA 23323	леп	
(X4) ID	SHAMARY STA	TEMENT OF DEFICIENCIES					1
PREFIX TAG	(EACH DEFICIENCY	/ 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)	8E	(X5) COMPLETION DATE
F 810 SS=D		Eating Equipment/Utensils	F8	310			
	§483.60(g) Assistive	a davinas		I		,	5/31
					F 810 Assistive Devices- Eating	,	-
	The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks.		•		Equipment/Utensils	e y	2019
		IT is not met as evidenced			1. Resident # 1 Rocker Knife was	٠	
	by:	I IS not met as evidenced			placed on the meal tray card	į.	
		ion, resident interview, staff					
	interviews, clinical re	ecord review, and review of			on		
		he facility staff failed to			4/14/2019.		
		eating device to a resident			2. 100% audit of Resident with	- 1	
		prove their ability to eat of 44 residents (Resident			assistive eating devices were	]	
	#11), in the survey s				conducted on 4/18/2019 by t	he	i
ł	" (1), in the ourvey o	ample.			Regional Director of Clinical		
	The facility staff fails	The facility staff failed to provide Resident #11				-	
	with the ordered Ro	cker knife during the midday			Operation.		
	meal on 4/11/19 and	J 4/12/19.		ļ	•		
	The findings include					ĺ	
	The findings include	a:			3. On 4/18/2019 Training was		
	Resident #11 was or	riginally admitted to the facility			provided to the Dietary mana	ige by	
	3/12/15 and readmit	ited 4/12/17 after an acute			the Regional Director of Clinic	cal	
1	care hospital stay. T	he current diagnoses			operation on Tray accuracy to		
	included intellectual	disability, right hemiparesis			include Assistive meal devices		
	and cerebral palsy.	Canada Caraga					
	The questorly Minim	Data Cat /MDC)			availability of the equipment a	at the	
	The quarterly Minimus assessment with an	assessment reference date			time of meal service.	1.	
	(ARD) of 1/14/19, co						
	completing the Brief	Interview for Mental Status					
	(BIMS) and scoring	15 out of a possible 15. This				- 1	
<b>j</b> 1	indicated Resident #	11's cognitive abilities for		l			
***	(Physical functioning	g are intact. In section "G"  j) the resident was coded as					
	requiring supervision	n of one person with eating,				- Transmission	]
	rodusing adpervision	rol one person with eating,					

	FOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED	
		495330	B. WING			İ	С
NAME OF	PROVIDER OR SUPPLIER	120000	[ D. 1111(G.		TOTAL TOOLS OF A CONTROL OF THE CONT	04/	16/2019
MANUE OF	FHOUDEN ON SUFFEIEN				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			117 GEORGE WASHINGTON HIGHWAY NO	RTH	
				C	HESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFID TAG	<b>(</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 810			F 8	10		:	
	extensive assistance	e of one person with bed		-			
	mobility, transfers, I	ocomotion, dressing, and			A Mool Sonder and the contract		
	personal hygiene ar	nd total care with toileting, and			4. Meal Service audit to include		
	bathing. On the 1/1	4/19, MDS assessment in			availability and use of adaptiv	e	
	section "P0100" (Pf	nysical Restraints), Resident			equipment will be conducted	3x	
	#11 was coded as u	itilizing a limb restraint daily.			day x 4 weeks then weekly du	rima	
	Review of the April	2019, physician order			random re-s-t	ring	
	summary revealed t	the following order dated			random meals service times b	y the	
	5/21/18: Regular die	et, regular texture, Lactose			Dietary Manager/ DON/UM.		
	intolerance, Serve 2	boiled eggs, no gravy, and					
	Rocker knife with so	coop plate related to					
		the right dominant side.				-	
	Dysphagia, orophar	yngeal phase, and other					
	mega colon.				Results of all reviews and audits wi incorporated into the Center's QAP		
					process to answer the Center's QA	PI [	
	Review of the nutriti	on care plan dated 7/31/18,			process to ensure compliance is	ļ	
		sistive eating devices; a		1	achieved and sustained.		
	Rocker knife or scor	op plate.				***************************************	
	On 4/11/19 at 12:30	p.m., the resident was					
	observed in the dinit	ng room during lunch. The					Ī
	resident presented v	with right upper extremity				****	
	nemparesis, his me	al was served in a scoop knife wasn't present. The				İ	1
ļ	resident had a crittor	d cheese sandwich which					
ļ	required cutting but	experienced difficulty					ł
į		ave the most appropriate		-			
	assistive device.	avo ino moot appropriate					1
							and the same of th
	An interview was co	nducted with the Dietary		-		]	ŀ
		at 12:50 p.m., the Dietary					
		ident #11 utilized a specialty				Tarian about	-
ł	knife at each meal a	nd apparently it didn't come					
	back to the kitchen f	rom the breakfast meal but					
	she would follow-up	on it. Upon return the Dietary				***************************************	
	Manager stated she	had retrieved the Rocker				Ì	l
	knife and she would					į	l
	Hehabilitation Depar	tment to obtain a second				i	

TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DAT DEFICIENCY)	STATEMEN AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(хз	) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAY NORTH  CHESAPEAKE, VA 23323  (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX  (EACH CORRECTIVE ACTION SHOULD BE COMPLIANT OF COMPLIANT			495330	B. WING			<del>-</del>
GREENBRIER REGIONAL MEDICAL CENTER  1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG  1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323	NAME OF	PROVIDER OR SUPPLIER		<u> </u>			04/16/2019
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLIANTE DAY CROSS-REFERENCED TO THE APPROPRIATE DAY DEFICIENCY)	GREENE	BRIER REGIONAL ME	DICAL CENTER		1017 GEORGE WASHINGTON HIGHW		<b>i</b>
F.810. Continued From page 127	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	IX (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF	HOULD BE	(X5) COMPLETION DATE
	F 810	Continued From pa		F	310		
Rocker knife for events such as had occurred.  On 4/12/19 at approximately 12:15 p.m., Resident #11 was again observed in the dining room during the lunch meal, his meal consisted of a piece of crusted fish served in a scoop plate. The Rocker knife needed to cut the fish wasn't present but a regular butter knife was included in his eating utensils.  An interview was conducted with the Dietary Manager 4/12/19 at approximately 12:45 p.m. The Dietary Manager stated Resident #11's Rocker knife was cleaned after breakfast and package for use at the midday meal. The Dietary Manager spoke with the staff on duty in the dining room. She stated the staff reported the utensils all come from the kitchen package the same therefore; they are unable to determine if it is a resident specific item or general utensils. The Dietary Manager stated Resident #11's Rocker knife was located; they had been given to another resident by mistake. The Dietary Manager further stated she needed a system to identify resident specific assistive devices from the general population utensils.  The above findings were shared with the Administrator, Director of Nursing and the Corporate Consultant on 4/16/19 at approximately 1:40 p.m. The facility staff provided no additional information.  The facility's policy titled "Assistance with Meals" dated 7/2017 read under the heading "Residents who may benefit from assistive devices (special eating equipment and utensils) will be provided for residents who		On 4/12/19 at approful to the lunch meal, his crusted fish served knife needed to cut regular butter knife utensils.  An interview was commanager 4/12/19 at The Dietary Manager Rocker knife was of package for use at Manager spoke with room. She stated the come from the kitch therefore; they are uresident specific iter Dietary Manager stakife was located; the resident by mistake stated she needed a specific assistive despopulation utensils.  The above findings Administrator, Direct Corporate Consultary approximately 1:40 no additional information of the facility's policy the dated 7/2017 read under the difference of the facility's policy the dated 7/2017 read under the facility's policy the dated 7/2017 read under the facility's policy the dated 7/2017 read under the facility's policy the dated 7/2017 read under the facility's policy the dated 7/2017 read under the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility's policy the facility of	ents such as had occurred.  eximately 12:15 p.m., Resident erved in the dining room during meal consisted of a piece of in a scoop plate. The Rocker the fish wasn't present but a was included in his eating  enducted with the Dietary approximately 12:45 p.m. er stated Resident #11's leaned after breakfast and the midday meal. The Dietary at the staff on duty in the dining le staff reported the utensils all the nearly approximately 12:45 p.m. er stated Resident #11's Rocker and the midday meal. The Dietary are staff reported the utensils all the nearly determine if it is a more general utensils. The lated Resident #11's Rocker they had been given to another. The Dietary Manager further a system to identify resident exices from the general were shared with the stor of Nursing and the int on 4/16/19 at p.m. The facility staff provided ation.  itled "Assistance with Meals" inder the heading "Residents massistive devices read at its (special eating equipment)				

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TEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	407000		_			С
ME OF PROVIDED OR CURRENTS	495330	B. WING			04/	16/2019
ME OF PROVIDER OR SUPPLIER REGIONAL ME			1	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
REFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
handles, plate guard Infection Prevention CFR(s): 483.80(a)(*)  §483.80 Infection C The facility must est infection prevention designed to provide comfortable environ development and tradiseases and infection program.  The facility must est and control program a minimum, the following services under the staff, volunteers, vist providing services unarrangement based conducted according accepted national staff. (i) A system of surver possible communication infections before the persons in the facility (ii) When and to who	verware with enlarged/padded ds and/or specialized cups.  a & Control I)(2)(4)(e)(f)  ontrol tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable ons.  prevention and control tablish an infection prevention (IPCP) that must include, at a wing elements:  tem for preventing, identifying, ng, and controlling infections diseases for all residents, itors, and other individuals nader a contractual upon the facility assessment of to §483.70(e) and following andards;  In standards, policies, and rogram, which must include, it illance designed to identify able diseases or y can spread to other	F {		O Infection Prevention and Control  On 4-12-2019 Resident #79 wo assessed for signs and sympton infection. Wound care was pro- using clean technique and obse the Regional Nurse Consultant. Wound MD was notified on 4-1 by the Regional Nurse Consulta Weekly wound assessment and evaluation conducted for any si infection by the Wound MD. Or 2019 the Treatment Cart suppli removed. The Treatment Cart w wiped out thoroughly using a ge cleaner. The container of 4x4 w removed and replaced with new supplies. The Dankins solution container was thoroughly cleane replaced into the clean treatme Clean scissors x3 pair were place the Treatment Cart. On 4-13-20 #2 received 1:1 retraining on Inf Control during wound care conce by the Regional Nurse Consultar	und wa ns of vided rived by The 3-2019 nt. gns of 14-12- es were vas ermicida ere v ed and nt cart. ed into 19 LPN fection fucted	/ al

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

Event ID: EQPC11

Facility ID: VA0043

If continuation sheet Page 139 of 147 RECEIVED

MAY 28 2019

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION		E SURVEY IPLETED
		405000	0 WW0			ĺ	С
11115.05	DDD: 45	495330	B. WING			04/	16/2019
NAME OF	PROVIDER OR SUPPLIER			Į.	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER		3	1017 GEORGE WASHINGTON HIGHWAY NO	RTH	
				(	CHESAPEAKE, VA 23323		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION . DATE
F 880	to be followed to pre (iv)When and how is resident; including be (A) The type and dudepending upon the involved, and (B) A requirement the least restrictive posticircumstances. (v) The circumstance must prohibit emploid disease or infected contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact with residen contact will transmit (vi)The hand hygien by staff involved in contact with residen contact with residen contact with residen contact with residen contact with residen contact with residen contact with residen contact with residen contact with resident conta	ansmission-based precautions event spread of infections; solation should be used for a put not limited to: tration of the isolation, infectious agent or organism that the isolation should be the sible for the resident under the resident under the resident under the resident under the resident under the resident under the resident under the resident expects of their food, if direct the disease; and reprocedures to be followed direct resident contact.  Therefore, process, and resident the spread of review.  The program, as necessary.  The is not met as evidenced on, staff interview, facility and clinical record review, it facility staff failed to maintain	F	380	the laundry area on 4-10-2019 bags containing the residents of and the towels that were leaning against the wall were removed. Housekeeping Supervisor and the Administrator. These items wer washed and dried using proper infection control technique. On 2019 Bins for cleaning clothing of provided and resident clothing of placed in the bins by the Housel Supervisor.  All residents have the potential affected.	lothing ng by the he 4-11- were were keeping to be ining es and	
	observation for one osample, Resident #7	otices during wound care of 44 residents in the survey 9.				- I ye yaqa dababan weda ye	The state of the s

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA . IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		405000	]				С
NAME OF	DOOMDED OD BLIDDLIED	495330	B. WING			04/	16/2019
IVAIVIE OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			017 GEORGE WASHINGTON HIGHWAY NO	RTH	
				С	CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 140	F8	80			
		acility staff failed to maintain	. 0				
	infection control pra	ctices during wound care					
	observation of his ri	ght heel pressure ulcer (1).		ł	Housekeeping on Infection Co	: امعادما	
						лиот	
	(1) A pressure ulcer	is an inflammation or sore on			Prevention in Laundry Care.		
	the skin over a bony	prominence (e.g., shoulder			4. Infection Control Prevention	•	,
	from prolonged pro-	uttocks, or heel), resulting			audits will be conducted 3x w	eek x4	
	from being confined	ssure on the area, usually to bed. Most frequently seen			weeks then 1x week by the		
	in elderly and immol	bilized persons, decubitus			Administrator or Designee. In	faction	ļ
	ulcers may be preve	ented by frequently change of			_		
	position, early ambu	lation, cleanliness, and use of			Control Clean Dressing Chang		
	skin lubricants and a	a water or air mattress. Also			will be conducted 3x week x4		
	called bedsores. Pre	essure sores. Barron's			then 1x week x4 weeks then monthly x3		
	Dictionary of Medica	Al Terms for the Non Medical A. Rothenberg, M.D. and			months by the DON/ADON. T	ne audit	s
	Charles F. Chapmai	n Page 155		ĺ	will be documented and main		
	Thanks I. Oraphia	1. 1 ago 100.			the Administrator's office. Res		· .
	The findings include	:			the training and audits will be		
	Resident #79 was a	dmitted to the facility on			presented Monthly to the QA		
	12/11/18 with diagno	oses that included but were			committee by the Administrat		or
ĺ	not limited to Pressu	re Ulcer of the right heel,			DON	or and	01
į	stage 4 (2), type two	diabetes mellitus, multiple			DON	1	
[	sclerosis (3) and hig	h blood pressure. Resident			* elektric		
	#/9's most recent M	DS (minimum data set)					
	ARD (accomment re	uarterly assessment with an eference date) of 3/18/19.				į	
	Resident #79 was co	oded as being cognitively		ł		***************************************	
	intact in the ability to	make daily decisions scoring			5. Completion Date 5/31/2019		1
	13 out of 15 on the E	BIMS (Brief Interview for			5. 56piction Date 3/31/2019	-	
	Mental Status) exam						
	Review of Resident	#79's April 2019 Physician					
	Order Sheet revealed	d the following order: "Dakins					
	Solution Apply to rial	nt heel topically every day				- Province of the second secon	
	shift for wound care	cleanse area with dakins, pat				į	
-	dry, and skin prep pe	eriwound area, apply dakins					
	moisten gauze to wo	und bed. cover (sic) with dry					

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) DAT COM	E SURVEY
					2000		С
	······································	495330	B. WING	·		04/	16/2019
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENE	BRIER REGIONAL ME	DICAL CENTER			1017 GEORGE WASHINGTON HIGHWAY NO	RTH	
				,	CHESAPEAKE, VA 23323		
(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 APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	Continued From pa	ge 141	F 8	 386			
	-	=	, ,	,00			-
	On 4/10/19 at 1:29 with LPN (Licensed conducted. LPN #2 nurse was not availate to do wound care. L grab gauze from a shands and then place paper on top of the was not wrapped in was then observed paper towels and the off Resident #79's begives and then put Resident #79's beds supplies (house stock bottle of Kerlix on top Reside #2 then took her scient and placed them on LPN #2 did not sanitate. LPN #2 donned a new removed the old dred 4/9/18. LPN #2 and washed her har gloves and cleaned normal saline and gatouched with her bar applied skin prep to LPN #2 then applied skin prep to LPN #2 then applied skin prep to LPN #2 then applied skin prep to LPN #2 then applied she had touched with	p.m., wound care observation Practical Nurse) #2 was stated that the wound care able that day and that she had PN #2 was first observed to stock package with her bare be the gauze onto a piece of treatment cart. The gauze individual wrapping. LPN #2 running plain water over en used these towels to wipe edside table. LPN #2 stated, flunch here." LPN #2 donned dry paper towels on top of side table. LPN #2 then put ck bottle of normal saline, of Dakins, and package of ent #79's bedside table. LPN ssors from her scrub pocket to the table with the supplies. tize her scissors at this time. ew pair of gloves and ssing. This dressing was #2 then removed her gloves ads. LPN #2 donned new Resident #79's wound with auze pads that she had re hands prior. Next, LPN #2 the outside of the wound. I dakins to a gauze pad that the her bare hands, and placed					
ŀ	R Over the Wound be	d. LPN #2 then covered the				1	-
j	yauze pad with a me	epilex border. LPN #2 then 79's heel in Kerlix and cut the			t manual to a	***************************************	
-	kerlix using the unea	nitized scissors. LPN #2 put			***	The same of the sa	
ļ	the rest of the unuse	d kerlix back in the package				An observed a bit	
	and placed it into he	r scrub pocket. The wrapper				Acceptable Acc	

I AND PLAN OF CORRECTION INCLINITIES ATTOM ASSAURA		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
							С		
		495330	B. WING	**********		04/	16/2019		
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE				
CDEENIE	DIED DECIONAL ME	DICAL CENTED	1017 GEORGE WASHINGTON HIGHWAY NORTH						
GREENBRIER REGIONAL MEDICAL CENTER			-	Cl	HESAPEAKE, VA 23323				
(X4) ID		TEMENT OF DEFICIENCIES	ID	$\overline{}$	PROVIDER'S PLAN OF CORRECTION	4	(X5)		
PREFIX TAG	(EACH DEFICIENCY REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPS DEFICIENCY)	BE	COMPLETION DATE		
F 880	Continued From pa	ge 142	F8	80					
	was open in her scr	ub pocket. LPN #2 then							
	washed her hands.	LPN #2 then placed the							
	house stock saline,	Dakins solution and kerlix							
	back into the treatm	ent cart. LPN #2 did not							
		tock bottles of saline and							
		ng them back into the		ı					
		#2 was not observed to					, , , , , , , , , , , , , , , , , , ,		
	sanitize her scissors	s after wound care.							
	On 4/11/19 at 2:55 a	a.m., an interview was					HANGE -		
	conducted with LPN	#2. When asked how to					T ( )		
		ontrol during wound care, LPN							
	#2 stated that she w	ould wash hands and wear			•				
		d care. When asked how she							
	cleaned Resident #7	79's bedside table, LPN #2				1			
		hand sanitizer from the wall							
		lean his bedside table. When							
	told LPN #2 the abo	ve observations, LPN #2							
		wiped his table down again							
		some food debris was stuck							
		nch. When asked how she is							
		.PN #2 stated that she didn't				ļ			
ļ	have to wear gloves	when removing gauze pads							
		k because had washed her				APPROXIMATION OF THE PROPERTY			
1	nands after doing he	er last wound (on a different				Petition			
		d confirm that all gauze pads		ļ					
		n Resident #79's wound.		esphedalis					
		iece of paper that she placed		Ì		į			
ļ		n top of was clean, LPN #2		1		-			
ļ		t okay to put gauze pads on a use of infection control. When		1					
}		saline and Dakins solution					1		
		ent #79's wound was a house							
		used on all residents, LPN #2		1					
		S. When asked if it was okay				1	1		
	to take the house et	ock bottles into the residents'				and the same of th	İ		
		ed that nurses could take				Ī	į		
		into resident's rooms. LPN #2		1		ļ	1		
		ock bottles did not have to be							

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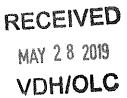
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405000	, www.c				С
NAME OF	D00/4055 00 01/55/45	495330	B. WING			04/	/16/2019
NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER				1	TREET ADDRESS, CITY, STATE, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	disinfected prior to parte treatment cart. LPN were contaminated, store her scissors in sanitize them prior to stated that she usus scissors before doin her scrub top was cothink it was clean." Wher scrub top pocked LPN #2 stated her parte clean, LPN #2 stated clean."  On 4/12/19 at 1:32 patter clean."	placing them back into the #2 stated only if the bottles When asked if it was okay to her scrub pocket and not to use on a resident, LPN #2 ally wipes (cleans) her ng a dressing. When asked if lean, LPN #2 stated, "I would When asked what else was in at with the scissors on 4/10/19, hens. If asked if her pens were d, "I guess not completely  D.m., ASM (administrative he administrator and ASM #4, if Nursing) were made aware	F	380			

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

Event ID: EQPC11

Facility ID: VA0043

If continuation sheet Page 144 of 147



STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(×	(3) DATI COM	E SURVEY PLETED		
		495330	B. WING				) 16/2010		
NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  1017 GEORGE WASHINGTON HIGHWAY NORTH						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION SHOULD E		BE COMPLETION			
	extend into muscle (e.g., fascia, tendon osteomyelitis possilivisible or directly pa obtained from the N Advisory Panel web http://www.npuap.or  (3) Multiple sclerosis disease that affects damages the myelin surrounds and prote damage slows down between your brain symptoms of MS. Ti from The National Ir https://medlineplus.g Based on observation documentation revie a sanitary environmed development and trainfection.  The facility staff failed clothing and failed to manner to prevent the infection.  The findings included On 04/10/19 at appropherous manner to the laundry room to th	and/or supporting structures or joint capsule) making ole. Exposed bone/tendon is lipable. This information was lational Pressure Ulcer site at rg/pr2.htm.  Is (MS) is a nervous system your brain and spinal cord. It is sheath, the material that lects your nerve cells. This is or blocks messages and your body, leading to the his information was obtained institutes of Health. It is gov/multiplesclerosis.html. It is prevent the lansmission of disease and the facility failed to ensure the ent to prevent the lansmission of disease and the potential spread of the laundry room with and to the following was observed:  In expectation of the laundry room with the clean area the following was observed:  In each of the laundry room with the resident's socks for under the folding table;	F 8	· ·					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED		
		495330	B. WING			C 04/16/2019			
	PROVIDER OR SUPPLIER  BRIER REGIONAL ME	DICAL CENTER		1	STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323		16/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE		
	clothing were sitting dryers; the bags we 3. A large stack of the large trash bag of reagainst the wall.  An interview was concentrated as a large trash bag of reagainst the wall.  An interview was concentrated as a large trash bag of reagainst the wall.  An interview was concentrated as a large trash bag of reagainst the wall.  An interview was concentrated as a large trash as a large trash as a large trash and to be on the large trash and towels remains asked, "Should the reagainst the stand of the large trash as a large tras	ags with the resident's on the floor next to the re open to air.  Towels was sitting on top of a seident's clothing leaning up on the same day at the surveyor desidents clothing be sitting on the same in trash bags or the painst the wall." She replied, residents clothing have in trash bags sitting on the	FE	380					
	times." He observed trash bags and the to wall. He stated, "The be washed again bed He said this could ca problem because the	I the clothing on the floor in owels leaning up against the e clothes and towels have to cause they are now soiled." have a major infection control e germs can also fall from the the floor where the resident's				Argenta (197) 1167 m manana majaparen diskata da manana majaparen			

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NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  (X4) ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 880  Continued From page 146 clothing are being stored. The resident clothes need to be off the floor and kept off the floor at all times.  A briefing was conducted on 04/11/19 at approximately 4:55 p.m., with the Administrator and Interim Director of Nursing (IDON). The facility did not present any further information about the findings.	STATEMENT OF DEFICIENCIES (X1) PROVIDER, AND PLAN OF CORRECTION IDENTIFICA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3)	DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER  GREENBRIER REGIONAL MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 880  Continued From page 146 clothing are being stored. The resident clothes need to be off the floor and kept off the floor at all times.  A briefing was conducted on 04/11/19 at approximately 4:55 p.m., with the Administrator and Interim Director of Nursing (IDON). The facility did not present any further information			495330	B. WING	····	С				
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	F 880	clothing are being s need to be off the flatimes.  A briefing was cond approximately 4:55 and Interim Director facility did not prese	tored. The resident clothes oor and kept off the floor at all ucted on 04/11/19 at p.m., with the Administrator of Nursing (IDON). The	F						

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

Event ID: EQPC11

Facility ID: VA0043

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