PRINTED: 06/12/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495142	B. WING		R 06/05/2019	
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
{E 000}	Initial Comments		(E 000)			
{F 656}	standard survey con 4/25/19, was conducted Corrections are requirements. Unce identified within this ideficiencies are identified within this 136 at the time of the consisted of nine cu (Residents #100 throws #108 through #109) (Resident #107). Develop/Implement CFR(s): 483.21(b)(1) \$483.21(b) Comprehe §483.21(b) (1) The face	edicare/Medicaid revisit to the ducted 4/23/19 through sted 6/4/19 through 6/5/19. Sired for compliance with 42 al Long Term Care corrected deficiencies are report. Corrected tified on the CMS 2567-B. 76 certified bed facility was a survey. The survey sample rrent Resident reviews bugh #106 and Residents and one closed record review. Comprehensive Care Plan ensive Care Plan cility must develop and	{F 000}	E000: This Plan of Correction is submitted in accordance with established state and federal laws. Submission of this Plan of Correction is not an admission of a deficiency existing of that a deficiency was cited correctly, it constitutes written allegation of compliance for deficiencies cited. F- 656		
§483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required			supervisors observed oxygen concer further discrepancies were observed. 2: Current residents receiving oxygen potential to be affected by this pract. 3: Nurses and certified nursing assist serviced on policy for oxygen adminit observation of oxygen concentrator implementation of care plan intervel Documentation in the electronic meaninplemented to record the flow met residents on oxygen every shift.	I. In therapy have tice. Itants will be instration and proper flow setting as well as intions. It dical record will be		

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

VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	PLE CONSTRUCTION G		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP (380 MILLWOOD AVENUE WINCHESTER, VA 22601	ODE	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T OEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{F 656}	provided due to the under §483.10, incommendations findings of the PAS rationale in the resident's represent (iv) In consultation resident's represent (A) The resident's desired outcomes. (B) The resident's desired outcomes. (B) The resident's future discharge. Find the resident's future discharge. Find the resident's future discharge plan plan, as appropriate requirements set for section. This REQUIREME by: Based on observation in the resident of the resident's for this purities,	83.25 or §483.40 but are not e resident's exercise of rights cluding the right to refuse 483.10(c)(6). d services or specialized ces the nursing facility will to f PASARR If a facility disagrees with the SARR, it must indicate its sident's medical record, with the resident and the ntative(s)-goals for admission and preference and potential for facilities must document nt's desire to return to the sessed and any referrals to cies and/or other appropriate rpose, in the comprehensive care e, in accordance with the both in paragraph (c) of this earl record review and facility it was determined that facility ment the comprehensive care residents in the survey # 101, # 102 and # 103. If ailed to implement Resident # ve care plan for the	{F 65	4: The director of nursing of equipment settings weekly immediately, and report to addressed per policy. Audit the weekly risk management problems will be reported to 5: Completion date: 06/21/	r, and address any the director of n t findings will be o nt meeting. Any o to the QA commi	y discrepancies oursing to be discussed at ongoing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495142	B WING_		R 06/05/2019	
	PROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COS (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION	
{F 656}	Continued From page administration.	2	{F 65	6}		
		ed to implement Resident e care plan for oxygen				
	The findings include:					
	The facility staff fai 101's comprehensive administration of oxyg					
	07/14/2015 with a reading diagnoses that include shortness of breath, a	dmitted to the facility on dmission of 03/24/2016 with ed but were not limited to trial fibrillation (1), gastroesophageal reflux				
	data set), a quarterly a (assessment reference Resident # 101 as sco assessment for menta of 0 - 15, 6 (six) - being				1.2	
	101 was coded as requor of one staff member for	aily decisions. Resident # uiring extensive assistance ir activities of daily living staff members for bathing.				
	06/05/19 at 7:20 a.m., 101 revealed he was ly oxygen from an oxygen nasal cannula. Observathe oxygen concentrate	o.m., at 3:05 p.m., and on observations of Resident # ying in bed receiving in concentrator through a vation of the flow meter on or revealed the oxygen flow a-half and three liters per				

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0011101	COT OTT MEDICATIVE	WINEDIONID OFICATOR			OIVID INO. 0936-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(×3) DATE SURVEY COMPLETED
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		495142	B WING_		06/05/2019
	ROVIDER OR SUPPLIER	HAB	_	STREET ADDRESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601	CODE
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
{F 656}	Continued From pa	age 3	{F 6	56)	1
	(two liters) via (by)	mented, "02 (oxygen) @ (at) 2L n/c (nasal cannula) to maintain ck sat (saturation) q (every)			ŧ:
	with a target date o "Focus. The reside (SOB) at bedtime fr 03/03/2017." Unde	e care plan for Resident # 101 f 08/29/2019 documented, ent has shortness of breath requently. Date initiated: or "Interventions/Tasks" it 2 @ [at] 2L via n/c to maintain ock sat Q shift."			
	observation was co practical nurse) # 1 purpose of the com stated, "For staff to plan of care, such a provide care. It give resident." After rev comprehensive can 08/29/2019 for shor asked if the care pla the oxygen was not	Da.m., an interview and nducted with LPN (licensed). When asked to describe the prehensive care plan, LPN # 1 be aware of their (resident's) as how they eat or drink, es you a picture of the liew, Resident # 101's e plan with a target date of thess of breath LPN # 1 was an was being implemented if being administered at two PN # 1 stated, "No."			
	"2. The facility will of comprehensive pen- each resident, that if and timeframes to in nursing and mental	are Planning" documented, develop and implement a son-centered care plan for include measurable objectives neet a resident's medical, and psychosocial needs as it the comprehensive Resident			





Facility ID: VA0218

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495142	B_ WING _		R
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 380 MILLWOOD AVENUE WINCHESTER, VA 22601	P CODE
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ([EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIAT & DATE
{F 656}	(administrative staff nadministrator, and AS were made aware of No further information References: (1) A problem with the heartbeat. This information the website:	eximately 10:00 a.m., ASM nember) #1, the SM #2, director of nursing,	{F 6:	56}	
	taken from the websit https://medlineplus.go (3) Stomach contents the esophagus and in was obtained from the https://www.nlm.nih.g 2. The facility staff fail #102's comprehensive administration. Resident #102 was ac 3/5/18. Resident #100 were not limited to promuscle weakness. Re MDS (minimum data swith an ARD (assessm 3/4/19, coded the residaily decision-making)	to leak back, or reflux, into intate it. This information we website: ov/medlineplus/gerd.html. ed to implement Resident e care plan for oxygen dmitted to the facility on 2's diagnoses included but eumonia, diabetes and esident #102's most recent set), a quarterly assessment ment reference date) of dent's cognitive skills for as severely impaired, ident #102 as requiring of one staff with bed it personal hygiene.			

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

Event ID: 06XQ12

Facility ID: VA0218

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI. IDENTIFICATION NUMBER: A. BUILDIN		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495142	B. WING			R 06/05/2019	
	ROVIDER OR SUPPLIER	B	STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
{F 656}	oxygen at two liters. comprehensive care documented, "The red rit (related to) shortnessETTINGS: 02 (oxyg@ 2LPM (liters per m oxygen at 12:05 p.: 7:48 a.m., Resident # bed receiving oxygen resident's nose. During oxygen concentrator wone and a half and two middle of the ball in the one and a half and	s order dated 3/25/19 for Resident #102's plan dated 5/9/18 sident has oxygen therapy ess of breathOXYGEN en) via NC (nasal cannula)	{F 656	5}			
	LPN #2 was asked ho administered at the ph LPN #2 stated, "Check ones in the computer." the ball in the oxygen should be positioned in physician's order for the "You need to check it aline." When asked whight on the line, LPN #2 stated oxygen checked every two hosometimes the concernesidents are transferr asked how nurses ensiresidents' care plans, access to it through (n	icensed practical nurse) #2. w nurses ensure oxygen is hysician prescribed rate. k the orders. The current " LPN #2 was asked where concentrator flow meter f a resident has a vo liters. LPN #2 stated, at eye level and right on the at part of the ball should be #2 stated, "The middle." concentrators should be urs. LPN #2 stated that attrators get knocked when ed out of bed. LPN #2 was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495142	B. WING		R 06/05/2019
	PROVIDER OR SUPPLIER	AB	STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
{F 656}	Continued From pag	e 6	{F 656	5}	
	a change, the care p sticky notes to update	lan coordinator will send e us as well."			
	I. Control of the con	.m., ASM #1 (the SM #2 (the director of aware of the above concern.			
	flowmeter, locate the the flowmeter. Next,	nted, "To properly read the prescribed flowrate line on turn the flow knob until the Now, center the ball on the			N EI
		e Planning" documented, eceive the services and/or			
	No further information	n was presented prior to exit.			ja:
		led to implement Resident e care plan for oxygen			
	3/15/19. Resident #1 were not limited to uri failure and shortness most recent MDS (mi. assessment with an Adate) of 5/2/19, coded cognitively intact. See	dmitted to the facility on 03's diagnoses included but nary tract infection, heart of breath. Resident #103's nimum data set), a quarterly ARD (assessment reference of the resident as being ction G coded Resident ensive assistance of two or obility and toilet use.			
	Review of Resident # revealed a physician's	103's clinical record s order dated 3/18/19 for			

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		NSTRUCTION	(X3) DATE SURVEY COMPLETED
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	- · ·	495142	B. WING			06/05/2019
	PROVIDER OR SUPPLIER	В		380 M	ET ADDRESS, CITY, STATE, ZIP CODE HILLWOOD AVENUE CHESTER, VA 22601	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
{F 656}	oxygen at two liters. I comprehensive care produmented, "OXYGE via NC @ [at] 2LPM (I On 6/4/19 at 12:10 p.r	Resident #103's plan dated 3/21/19 EN SETTINGS: 02 (oxygen)	{F 65	56}		
	via a nasal cannula in cannula was connecte concentrator. During oxygen concentrator v two and a half and the the middle of the ball i	the resident's nose. The ed to an oxygen each observation, the was set at a rate between ee liters as evidenced by in the flow meter set a half and three-liter lines. If the flow meter were				
	LPN #2 was asked hor administered at the ph LPN #2 stated, "Check ones in the computer," the ball in the oxygen is should be positioned if physician's order for tw "You need to check it a tine." When asked whight on the line, LPN #2 stated oxygen checked every two hos sometimes the concentresidents are transferresidents are transferresidents' care plans, access to it through (no	icensed practical nurse) #2. w nurses ensure oxygen is ysician prescribed rate. k the orders. The current t LPN #2 was asked where concentrator flow meter f a resident has a vo liters. LPN #2 stated, at eye level and right on the at part of the ball should be #2 stated, "The middle." concentrators should be urs. LPN #2 stated that trators get knocked when ed out of bed. LPN #2 was ure they implement LPN #2 stated, "We have ame of computer system). it up and usually if there is n coordinator will send				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495142	B WING		R
	ROVIDER OR SUPPLIER	НАВ		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601	06/05/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
{F 656}	Continued From pa	ige 8	{F 656}		
	The oxygen concer instructions docume meter to make sure centered on the line number of your flow. No further informatic Respiratory/Tracher CFR(s): 483.25(i) § 483.25(i) Respirat tracheostomy care at tracheostomy care at tracheostomy care and tracheal sic care, consistent with practice, the comprecare plan, the reside and 483.65 of this s This REQUIREMEN by: Based on observati interview and clinical document review, it staff failed to provide with professional stacomprehensive persfour of 10 residents	ASM #2 (the director of e aware of the above concern. atrator manufacturer's ented, "2. Check the flow that the flow meter ball is e next to the prescribed v rate." on was presented prior to exit. costomy Care and Suctioning and tracheal suctioning. Sure that a resident who are, including tracheostomy auctioning, is provided such in professional standards of ehensive person-centered ents' goals and preferences.	{F 695}	F-695 1: In this case upon notification by oxygen observation the oxygen equivas adjusted to the proper setting, spirometer was properly disposed management checked all oxygen coreported no further incidence. 2: Current residents receiving respit therapy/treatments have a potenti practice. 3: Clinical staff will be educated on for respiratory treatments and oxygon physician's orders, oxygen equip proper infection control storage of equipment. Documentation in the executed will be implemented to record will be implemented to record.	uipment for residents , and the incentive of and nurse oncentrators and ratory al to be affected by this policy and procedure gen, with an emphasis oment settings, and personal respiratory electronic medical
	The facility staff facility staff facility	ailed to store Resident #100's (1) in a sanitary manner.		record will be implemented to reco settings for residents on oxygen even Documentation will be put in place changing of respiratory storage equ	ery shift. to record proper

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	IO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B WING		=	0(R 6/05/2019
NAME OF F	PROVIDER OR SUPPLIER	· · · · · · · · · · · · · · · · · · ·		S	TREET ADDRESS, CITY, STATE, ZIP CODE		5,0012015
EVERGR	EEN HEALTH AND RE	EHAB	0,		80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE	(X5) COMPLETION DATE
{F 695}	Continued From p	age 9	{F 6	95)	4: The director of nursing designee v	مناسب دالنب	
 {F 695} Continued From page 9 2. The facility staff failed to administer Resident # 101's oxygen according to the physician's orders. 3. The facility staff failed to administer oxygen to Resident #102 at the physician prescribed rate of two liters. 				oxygen/respiratory equipment weel discrepancies to the director of nurs according to policy. Audit findings wweekly risk management meeting. A will be reported to the QA committee	kly and reping to be a fill be discu	addressed assed at the	
	4. The facility staff	failed to administer oxygen to he physician prescribed rate of			5: Completion date: 06/21/2019		II.
	The findings include	de:					11
	and the second s	failed to store Resident #100's er (1) in a sanitary manner.					11
	12/22/2005 with a diagnoses that include shortness of breatt	as admitted to the facility on readmission of 08/23/2017 with luded but were not limited to h, chronic obstructive a (2), benign prostatic agina (3).					
	data set), an annu- (assessment refere Resident # 100 as assessment for me of 0 - 15, 15- being daily decisions. Re requiring supervision	nost recent MDS (minimum al assessment with an ARD ence date) of 05/21/19, coded scoring a 15 on the staff ental status (BIMS) of a score g cognitively intact for making esident # 100 was coded as on with set-up for activities of pendent of one staff member					
	a.m., an observation revealed Resident	53 a.m., 3:05 p.m., and at 7:20 on of Resident# 100's room # 100's incentive spirometer ing on a small folding table					

next to Resident # 100's bed.

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CEIALEL	STOR WEDIOARE	HILDICAID SERVICES			OMB NO. 0938-0	<u> </u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	COMPLETED	
		495142	B. WING		R 06/05/2019	1	
	ROVIDER OR SUPPLIER	AB		STREET ADDRESS, CITY, STATE, ZIP 380 MILLWOOD AVENUE WINCHESTER, VA 22601			
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{F 695}	Continued From pag	e 10	{F 6	95}			
	The "Physician's Ord documented, "Incent						
	with a target date of "Focus. The residen status/difficulty breat	care plan for Resident # 100 06/09/2019 documented, it has altered respiratory hing r/t (related to) COPD bulmonary disease), SOB					
	initiated: 08/24/2017 "Interventions/Tasks' sustained deep brea (emphasizing slow in inspiration for a few s exhalation); Using in close for convenient	and Hypoxemia. Date " Under " it documented, "Encourage ths by: Using demonstration chalation, holding and seconds, and passive centive spirometer (place resident use); Asking ate initiated: 08/24/2017."					
	conducted with Resid	a.m., an interview was dent # 100. When asked if e spirometer Resident # 100					
	observation was con- practical nurse) # 1. is respiratory equipm When asked how it s use LPN # 1 stated,' not in use." LPN # 1 this surveyor to Resid observing the incenti	a.m., an interview and ducted with LPN (licensed When asked if a spirometer ent, LPN # 1 stated, "Yes." hould be stored when not in 'It should be bagged when was asked to accompany dent # 100's room. After we spirometer on Resident #					
	incentive spirometer a bag." LPN # 1 furtl bag for the spirometer resident's bedside tal	LPN # 1 stated that the should have been placed in her stated that there was a er in the drawer of the ble. After searching through N # 1 stated that there was					







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	OF DEFICIENCIES F CORRECTION	1 (· · · · · · · · · · · · · · · · · ·		(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
{F 695}	Continued From page	11	{F 6	95}	
	not a bag for the spiro immediately get one.	meter and that she would			T.
	(administrative staff madministrator, and ASI were made aware of the No further information.) References: (1) A device used to be healthy after surgery of illness, such as pneum spirometer teaches you breaths. Deep breathin well-inflated and healthy prevent lung problems the incentive spirometer instructed by your nurse an active role in your manactive role in your	M #2, director of nursing, he above findings. was provided prior to exit. elp you keep your lungs or when you have a lung nonia. Using the incentive to how to take slow deeping keeps your lungs only while you heal and helps like pneumonia. By using er, every 1 to 2 hours, or as see or doctor, you can take ecovery and keep your			
	can lead to shortness of was obtained from the https://www.nlm.nih.go (3) An enlarged prostatiobtained from the webshttps://www.nlm.nih.go statebph.html.	v/medlineplus/copd.html. te. This information was			







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FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495142	B. WING		R
	NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB			STREET ADDRESS CITY, STATE ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601	06/05/2019
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
(F 695)	07/14/2015 with a readiagnoses that include shortness of breath, a	dmitted to the facility on dmission of 03/24/2016 with add but were not limited to	{F 69	5}	
	data set), a quarterly a (assessment reference Resident # 101 as sco assessment for menta of 0 - 15, 6 (six) - being cognition for making d. 101 was coded as regiof one staff member for	recent MDS (minimum assessment with an ARD e date) of 02/25/19, coded ring a 6 (six) on the staff a status (BIMS) of a score g severely impaired of aily decisions. Resident # uiring extensive assistance r activities of daily living staff members for bathing.			
	101 revealed he was ly oxygen from an oxygen nasal cannula. Observithe oxygen concentrate	observations of Resident #			
	(two liters) via (by) n/c	ted, "02 (oxygen) @ (at) 2L (nasal cannula) to maintain sat (saturation) q (every)			
	with a target date of 08 "Focus. The resident h (SOB) at bedtime frequ 03/03/2017." Under "Ir	as shortness of breath ently. Date initiated:			

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PRINTED: 06/12/2019 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 R 495142 8. WING 06/05/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DESICIENCY {F 695} Continued From page 13 {F 695} above 90% check sat Q shift." On 04/05/19 at 7:30 a.m., an interview and observation was conducted with LPN (licensed practical nurse) # 1. When asked how an oxygen concentrator flowmeter was read, LPN # 1 stated, "The ball should be dead center on the line of what liter they're on." When asked what Resident # 101's oxygen flow rate should be LPN # 1 stated, 'It should be two liters per minute." LPN # 1 then stated she would check the physician's orders and accessed Resident # 101's HER (electronic health record). After reviewing the physician's orders for Resident # 101 on the computer LPN # 1 stated, "It should be two." After observing the flowmeter on the oxygen concentrator in Resident # 101's room LPN stated, "It's at two-and -a half." LPN # 1 then adjusted the flow rate to two liters. The (Name of Oxygen Concentrator Manufacturer's Instructions) for Resident # 101's oxygen concentrator documented, "To properly read the flowmeter, locate the prescribe flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the Umin (liter per minute) line prescribed." On 06/05/19 at approximately 10:00 a.m., ASM

administrator, and ASM #2, director of nursing, were made aware of the above findings.

(administrative staff member) #1, the

No further information was provided prior to exit.

References:

(1) A problem with the speed or rhythm of the heartbeat. This information was obtained from the website:

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Review of Resident #102's clinical record revealed a physician's order dated 3/25/19 for oxygen at two liters. Resident #102's comprehensive care plan dated 5/9/18 documented, "The resident has oxygen therapy r/t (related to) shortness of breath...OXYGEN SETTINGS: 02 (oxygen) via NC (nasal cannula) @ [at] 2LPM (liters per minute)..."

On 6/4/19 at 12:05 p.m., 3:22 p.m. and 6/5/19 at 7:48 a.m., Resident #102 was observed lying in bed receiving oxygen via a nasal cannula in the

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	495142		B. WING _		R 06/05/2019
NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA. 22601		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE COMPLETION E APPROPRIAT E DATE
(F 695)	connected to an ox each observation, to set at a rate between as evidenced by the meter set between two-liter lines. These meter were conducted with LPN #2 was asked administered at the LPN #2 stated, "Chrones in the compute the ball in the oxyge should be positione physician's order for	e nasal cannula was ygen concentrator. During he oxygen concentrator was en one and a half and two liters e middle of the ball in the flow the one and a half and se observations of the flow ted at eye level. .m., an interview was I (licensed practical nurse) #2. how nurses ensure oxygen is physician prescribed rate. eck the orders. The current er." LPN #2 was asked where en concentrator flow meter d if a resident has a r two liters. LPN #2 stated,	{F 69	5}	
	line." When asked right on the line, LPL LPN #2 stated oxyg checked every two lesometimes the concresidents are transferent on 6/5/19 at 10:00 administrator) and Anursing) were made. The oxygen concentrictions docume flowmeter, locate that flowmeter. Next ball rises to the line. L/min (liter/minute) if	a.m., ASM #1 (the ASM #2 (the director of e aware of the above concern. trator manufacturer's ented, "To properly read the e prescribed flowrate line on the turn the flow knob until the Now, center the ball on the ine prescribed."			
		garding oxygen therapy irsing/therapy staff are			

PRINTED: 06/12/2019 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 495142 8 WING 06/05/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) IEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR USC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) {F 695} | Continued From page 16 {F 695} responsible for maintaining an adequate supply of oxygen to any resident requiring such." No further information was presented prior to exit. 4. The facility staff failed to administer oxygen to Resident #103 at the physician prescribed rate of two liters. Resident #103 was admitted to the facility on 3/15/19. Resident #103's diagnoses included but were not limited to urinary tract infection, heart failure and shortness of breath. Resident #103's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/2/19, coded the resident as being cognitively intact. Section G coded Resident #103 as requiring extensive assistance of two or more staff with bed mobility and toilet use. Review of Resident #103's clinical record revealed a physician's order dated 3/18/19 for oxygen at two liters. Resident #103's comprehensive care plan dated 3/21/19 documented, "OXYGEN SETTINGS: 02 (oxygen) via NC @2LPM (liters per minute)..." On 6/4/19 at 12:10 p.m. and 3:24 p.m., Resident #103 was observed lying in bed receiving oxygen via a nasal cannula in the resident's nose that was connected to any oxygen concentrator. During each observation, the oxygen concentrator was set at a rate between two and a

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half and three liters as evidenced by the middle of the ball in the flow meter set between the two and a half and three-liter lines. These observations of the flow meter were conducted at eye level.

On 6/5/19 at 9:37 a.m., an interview was

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				(X3) DATE SURVEY COMPLETED	
		495142	B. WING _	B. WING		R	
NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP COE 380 MILLWOOD AVENUE WINCHESTER, VA 22601	DE	06/05/2019	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		
{F 695}	LPN #2 was asked headministered at the p LPN #2 stated, "Checones in the computer the ball in the oxygen should be positioned physician's order for "You need to check it line." When asked wright on the line, LPN LPN #2 stated oxygen checked every two he sometimes the conceresidents are transfer. On 6/5/19 at 10:00 a. administrator) and AS nursing) were made as	clicensed practical nurse) #2. by nurses ensure oxygen is hysician prescribed rate. It is concentrated that a second resident has a second resident	{F 69	15}			
	meter to make sure the centered on the line in number of your flow in No further information. Resident Records - lo CFR(s): 483.20(f)(5), §483.20(f)(5) Resident (i) A facility may not resident-identifiable to (ii) The facility may represident-identifiable to accordance with a colagrees not to use or desident in the line in the colagrees of the line in the colagrees in the line in the colagrees in the line in th	ted, "2. Check the flow nat the flow meter ball is ext to the prescribed ate." was presented prior to exit. entifiable Information 483.70(i)(1)-(5) at-identifiable information that is the public. lease information that is	F 84	F-842 1: In this case upon notification inaccurate pain level docume and #105 and the lack of non-intervention documentation for responsible were reminded or documenting pain levels and interventions for pain manager	ntation for -pharmacoi for resident f the impor non-pharm	residents #102 logical t #102 the nurses tance of properly	



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INTERENT OF DEFICIENCES AND PLAN OF CORRECTION A BUILDING	OF ITTE	O I OIT MEDIONITE	G MEDIO ND GENTIOLO			O 141D 140, 0330-0331
NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFIDENCES (PAPER) REQUILATORY OR I.S.C. IDENTIFYING INFORMATION) F. 842 Continued From page 18 to do so. \$483.70(i) Medical records. \$483.70(i) Medical records. \$483.70(i) Medical records on each resident that are- (i) Complete: (iii) Accurately documented. (iii) Readily accessible, and (iv) Systematically organized \$483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law, (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.502; (iv) For public health activities, judicial and administrative proceedings, law enforcement purposes, or ground model on purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.502; \$483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or				20 33	CONSTRUCTION	
NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB X4 ID SUMMARY STATEMENT OF DEFICIENCIES WINCHESTER, VA 22601 X5 ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION F 842 Continued From page 18 to do so. \$483.70(i) (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented, (iii) Readily accessible, and (iv) Systematically organized \$483.70(i) (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is:- (i) To the individual, or their resident representative where permitted by and in compliance with 45 CFR 164.50E; (iv) For public health activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, organ donation purposes, fesearch purposes, organ donation purposes, fuseral forectors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.50E; (v) For public health activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, fuseral forectors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.51E. \$483.70(ii)(3) The facility must safeguard medical record information against loss, destruction, or						R
Semillawood Avenue Winchester, Value Val			495142	B. WING		06/05/2019
F 842 Continued From page 18 to do so. §483 70(i) Medical records. §483 70(i) 1 in accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are: (i) Complete, (ii) Accurately documented, (iii) Readily accessible, and (iv) Systematically organized §483 70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (iii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, judicial and administrative proceedings, law enforcement purposes, or goard donation purposes, research purposes, or goard donation purpose, research purposes, or goard donation purpose, research purposes, or goard donation purposes, research purposes, or goard donation purpose, research purposes, or goard donation purpose, research purposes, or goard donation purpose, or	EVERGREEN HEALTH AND REHAB			38	0 MILLWOOD AVENUE	
to do so. §483 70(i) Medical records. §483 70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented, (iii) Readily accessible, and (iv) Systematically organized §483 70(i)(2) The facility must keep confidential all information contained in the resident representative where permitted by applicable law; (ii) Required by Law; (iii) For inteatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, organ donation purposes, organ donation purposes, research purposes, organ donation purpose, organ donation purpose, organ donation purposes, organ donation purpose, organ	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	OULD BE COMPLETION
§483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or	F 842	to do so. §483.70(i) Medical §483.70(i)(1) In acc professional standa must maintain med that are- (i) Complete; (ii) Accurately docu (iii) Readily accessi (iv) Systematically of §483.70(i)(2) The fa all information conta regardless of the forecords, except who (i) To the individual, representative whei (ii) Required by Lav (iii) For treatment, p operations, as perm with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial ar law enforcement pu purposes, research medical examiners, a serious threat to h by and in compliance §483.70(i)(3) The fa record information a unauthorized use. §483.70(i)(4) Medic for-	records. cordance with accepted ands and practices, the facility ical records on each resident imented, ble, and organized accility must keep confidential ained in the resident's records, arm or storage method of the en release istor their resident applicable law; w; wayment, or health care nitted by and in compliance 06; h activities, reporting of abuse, c violence, health oversight and administrative proceedings, imposes, organ donation purposes, or to coroners, funeral directors, and to avert health or safety as permitted be with 45 CFR 164.512. Incility must safeguard medical against loss, destruction, or	F 842	the potential to be affected by this 3: Clinical staff will be educated or for accurate documentation of particular pharmacological interventions. Do electronic medical record will be produmentation of non-pharmacoresidents receiving PRN pain medical rector of nursing designer medication documentation weekly discrepancies immediately, and redirector of nursing. Audit findings weekly risk management meeting will be reported to the QA commits.	is practice. In policy and procedure in levels and non-ocumentation in the put in place to require plogical interventions for ications. We will audit PRN pain the port them to the will be discussed at the Any ongoing problems.





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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	100	IPLE CONSTRUCTION	СОМІ	(X3) DATE SURVEY COMPLETED	
		495142	5142 B WING			R 5/05/2019	
	ROVIDER OR SUPPLIER EEN HEALTH AND RE	EHAB		STREET ADDRESS, CITY, STATE, ZIP COD 380 MILLWOOD AVENUE WINCHESTER, VA 22601			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CO		(X5) COMPLETION		
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
F 842	Continued From p	age 19	F 8	42			
	there is no require	n the date of discharge when ement in State law; or years after a resident reaches tate law.					
	(i) Sufficient inform (ii) A record of the	medical record must contain- nation to identify the resident; resident's assessments; ensive plan of care and services					
	and resident revie determinations co	any preadmission screening w evaluations and nducted by the State; irse's, and other licensed				11 	
	professional's pro- (vi) Laboratory, ra- services reports a: This REQUIREME						
	and clinical record the facility staff fai	erview, facility document review review, it was determined that led to maintain a complete and ecord for two of ten residents in					
		, Residents #102 and #105.					
	non-pharmacologic provided to Reside acetaminophen ac	failed to document cal interventions that were ent #102 prior to as needed aministration on 5/30/19 and y document Resident #102's same date.					
		failed to document accurately ain level on 6/3/19.					
	The findings include	de:					
		failed to document cal interventions that were					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/GLIA (X2) MULTIPI IDENTIFICATION NUMBER: A. BUILDING		TIPLE CONSTRUCTION	C	(>3) DATE SURVEY COMPLETED	
	495142 B WING					R 06/05/2019	
	NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZI 380 MILLWOOD AVENUE WINCHESTER, VA 22601	PCODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 842	acetaminophen (1) a failed to accurate do level on that same do level on the level of	at #102 prior to as needed administration on 5/30/19 and cument Resident #102's pain ate. admitted to the facility on 02's diagnoses included but neumonia, diabetes and Resident #102's most recent a set), a quarterly assessment sment reference date) of sident's cognitive skills for g as severely impaired. Sident #102 as requiring a of one staff with bed and personal hygiene. #102's clinical record 's order dated 1/13/19 for mg (milligrams) - two tablets hours as needed for a pain Review of Resident #102's dication administration staminophen was dent #102 on 5/30/19 for a orther review of Resident I (including 5/30/19 nurses' all documentation that I interventions were provided	F	342	eact)		
	3/5/18 documented,	rventions such as back rubs, old compresses for					





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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	IDENTIFICATION NUMBER: A BUILDING			DATE SURVEY COMPLETED
	495142					R
	NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB			STREET ADDRESS, CITY, ST 380 MILLWOOD AVENUE WINCHESTER, VA 2260		06/05/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	X (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIAT E DEFICIENCY)	(X5) COMPLETION DATE
	was conducted with nurse) #3 (the nurse acetaminophen to Richem 1988) #3 (the nurse acetaminophen to Richem 1988) #3 stated she re washcloths to reside administering acetam on 5/30/19. LPN #3 she documented the interventions. When to document non-phate LPN #3 stated she withem in the nurses' nasked why she administrated to administrated to administrately documented to administrator) and Richem 1989 and 19	LPN (licensed practical who administered esident #102 on 5/30/19). epositioned and applied nt #102's forehead prior to ninophen to Resident #102 stated she was not sure if se non-pharmacological asked if she was supposed armacological interventions, as supposed to document notes. LPN #3 was also nistered acetaminophen for a nithe physician order nister the medication for a ve. LPN #3 stated she need the pain level and the was actually four or five. m., ASM #1 (the SM #2 (the director of aware of the above concern. ed, "POLICY FOR PAIN cumented, "2. A numbered in will be used for the ctively articulate by verbal ain and '10' being addition the resident will be ocation, onset, duration.	F	342		

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB NO. (<u>093</u> 8-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B WING			R 06/05/2019	
NAME OF P	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00,00	72013
EVERGRI	EEN HEALTH AND REHA	В		380 MIL	LWOOD AVENUE		
				WINCH	IESTER, VA 22601		
(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 APPROPE DEFICIENCY)	BE ((X5) COMPLETION DATE
F 842	Continued From page	e 22	F	842			
	from the website:		, ' '	042			
		ov/druginfo/meds/a681004.h					
	2. The facility staff fai Resident #105's pain						
	Resident #105 was a					-	
	5/19/19. Resident #1					1	
	were not limited to rig					- 1	
	chronic kidney diseas recent MDS (minimum					ľ	
	assessment with an A						
	date) of 5/26/19, code						
	cognitively intact. See						
	#105 as requiring exte						
	more staff with bed m						
	Review of Resident #						
	revealed a physician's					- !	
	acetaminophen (1) 32 tablets by mouth even						
	pain level of one to fiv					- 1	
	Resident #105's clinic						
	physician's order date					j	
	hydrocodone/acetamii	nophen (2) 10/325 mg- one		Ť			
	tablet by mouth every	four fours as needed for a					
	•	. Review of Resident					
	#105's June 2019 MA						
	administration record)						- 1
		nophen was administered to 19 for a pain level of four.					
	Resident #105's care	•					1
		ster pain medications as					
	ordered. Document le						
	On 6/5/19 at 9:37 a.m.	, an interview was					
	conducted with LPN (I	icensed practical nurse) #2					
	(the nurse who admini	stered					İ

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NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 842 Continued From page 23 hydrocodone/acetaminophen to Resident #105 on 6/3/19). LPN #2 was read the two above physician's orders and asked which medication should be administered for a pain level of four. LPN #2 stated, "The Tylenol (acetaminophen)." When asked why, LPN #2 stated, "Because the order specifies for the acetaminophen to Resident #105 for a documented pain level of four on 6/3/19. LPN #2 stated, "That must have been a data entry error." LPN #2 stated Resident #105 was in a lot of pain and tearing up when she administered hydrocodone/acetaminophen to the resident #105 was in a lot of pain and tearing up when she administered hydrocodone/acetaminophen to the resident on 6/3/19. On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concem. No further information was presented prior to exit.		STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL' A. BUILDI	FIPLE CONSTRUCT	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHAB (X4) ID PREFIX IDEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 842 Continued From page 23 hydrocodone/acetaminophen to Resident #105 on 6/3/19. LPN #2 stated, "The Tylenol (acetaminophen.)" When asked why, LPN #2 stated, "Tecause the order specifies for the acetaminophen." LPN #2 was made aware that she administered hydrocodone/acetaminophen to Resident #105 for a documented pain level of four on 6/3/19. LPN #2 stated, "The Tylenol (acetaminophen)." LPN #2 stated, "That must have been a data entry error." LPN #2 stated Resident #105 for a documented pain level of four on 6/3/19. LPN #2 stated, "That must have been a data entry error." LPN #2 stated Resident #105 was in a lot of pain and tearing up when she administered hydrocodone/acetaminophen to the resident on 6/3/19. On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.							R
EVERGREEN HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION F 842 Continued From page 23 hydrocodone/acetaminophen to Resident #105 on 6/3/19). LPN #2 was read the two above physician's orders and asked which medication should be administered for a pain level of four. LPN #2 stated, "The Tylenol (acetaminophen." LPN #2 was made aware that she administered hydrocodone/acetaminophen." LPN #2 was made aware that she administered hydrocodone/acetaminophen to Resident #105 for a documented pain level of four on 6/3/19. LPN #2 stated, "That must have been a data entry error." LPN #2 stated Resident #105 was in a lot of pain and tearing up when she administered hydrocodone/acetaminophen to the resident on 6/3/19. On 6/5/19 at 10:00 a.m., ASM #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.			495142	B. WING			06/05/2019
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 842 Continued From page 23	***				380 MILLWOOD	DAVENUE	
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(1) Acetaminophen is used to relieve mild to moderate pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a681004.h tml (2) "Hydrocodone is a painkiller in the opioid family (related to morphine). Acetaminophen is an over-the-counter medicine used to treat pain and inflammation. They may be combined in one prescription medicine to treat pain." This information was obtained from the website: https://medlineplus.gov/ency/article/002670.htm		hydrocodone/acetami on 6/3/19). LPN #2 w physician's orders and should be administere LPN #2 stated, "The TWhen asked why, LPI order specifies for the was made aware that hydrocodone/acetamin for a documented pain LPN #2 stated, "That rentry error." LPN #2 s a lot of pain and tearin administered hydrocodoresident on 6/3/19. On 6/5/19 at 10:00 a.m administrator) and ASI nursing) were made as No further information (1) Acetaminophen is a moderate pain. This infrom the website: https://medlineplus.gov.tml (2) "Hydrocodone is a family (related to morp an over-the-counter meand inflammation. The prescription medicine to information was obtain."	nophen to Resident #105 as read the two above d asked which medication d for a pain level of four. Tylenol (acetaminophen)." W #2 stated, "Because the acetaminophen." LPN #2 she administered hophen to Resident #105 I level of four on 6/3/19. must have been a data stated Resident #105 was in g up when she done/acetaminophen to the M #2 (the director of ware of the above concern. Was presented prior to exit. Used to relieve mild to information was obtained W/druginfo/meds/a681004.h painkiller in the opioid hine). Acetaminophen is edicine used to treat pain by may be combined in one to treat pain." This ed from the website:	F	342		



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VDH/OLC