Dec. 12. 2019 12:12PM

No. 1548 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 12/02/2019 **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0381 STATEMENT OF DEFICIENCIES (X1) PROVIDENSUPPLIENCLIA (X2) MULTIPLE CONSTRUCTION (X) DATE SURVEY AND PLAN OF CORRECTION DENTIFICATION NUMBER: COMPLETED : A. BUILDING 495330 B. WING 11/21/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, GITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH GREENBRIER REGIONAL MEDICAL CENTER CHESAPEAKE, VA 23323 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION OMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG TAG CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 | INITIAL COMMENTS F 000 000 An unannounced Medicare/Medicald abbreviated standard survey was conducted 11/19/19 through 11/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long This plan of correction is Term Care requirements, Two complaints were respectfully submitted in investigated during the survey. response to deficiencies cited The census in this 120 certifled bed facility was: 107 at the time of the survey. The survey sample on November 19 -21, 2019 consisted of 7 current Residents reviews complaint survey. This plan of (Residents #1 through #8) and 1 closed record review (Resident #7). correction constitutes a written F 580 Notify of Changes (Injury/Decline/Room, etc.) F 580 allegation of substantial CFR(s): 483.10(g)(14)(l)-(lv)(15) SS=D compliance with the Federal \$483.10(g)(14) Notification of Changes, (i) A facility must immediately inform the resident: Medicare and Medicaid consult with the resident's physician; and notify, requirements. The submission consistent with his or her authority, the resident representative(s) when there isof this plan of correction does (A) An accident involving the resident which results in injury and has the potential for requiring not constitute an agreement physician intervention; that the deficiencies exist, nor (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a is it an admission that they deterioration in health, mental, or psychosocial existed. It is an expression of status in either life-threatening conditions or clinical complications); the Facilities desire to fully (C) A need to alter treatment significantly (that Is, comply with the Medicare and a need to discontinue an existing form of treatment due to adverse consequences, or to Medicaid requirements. commence a new form of treatment); or (D) A decision to transfer or discharge the

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

(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that

resident from the facility as specified in

TITLE NHA (Xe) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other sateguards 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.

§483.15(c)(1)(ii).

DEPART	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		FC	TED: 12/02/2019 DRM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	IXI) PROVIDER/BUPPLIER/OLIA IDENTIFICATION NUMBER:		The Market Construction of Market Construction of the Construction	NO. 0938-0391 DATE SURVEY COMPLETED
[2]		496330	B, WING		C
NAME OF F	ROVIDEA OR SUPPLIER		Control of the second	STREET ADDRESS, CITY, STATE, ZIP CODE	11/21/2019
GREEN	RIER REGIONAL ME			ſ	
(X4) ID PREPIX TAG	(EACH CEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION COMPLETION
F 000	INITIAL COMMENT	8	F 000		
	standard survey wa 11/21/19. Correctlo compliance with 42	CFR Part 483 Federal Long tents. Two complaints were			
<b>5</b> 690	107 at the time of the consisted of 7 curre (Residents #1 throu review (Resident #7	20 certified bed facility was the survey. The survey sample int Residents reviews gh #6) and 1 closed record ).			
SS=D	GFR(s): 463.10(g)(1) §483.10(g)(14) Noti (I) A facility must for consult with the resi consistent with his c representative(s) wi (A) An accident invo- results in injury and physician interventic (B) A significant cha- mental, or payohoso deterioration in heal status in either life-ti clinical complication (C) A need to alter to a need to discontinu- treatment due to ad- commence a new fo- (D) A decision to tra resident from the fact §483.15(c)(1)(ii), (ii) When making no (14)(i) of this section	fication of Changes, mediately inform the resident; dent's physician; and notify, or her authority, the resident nen there is- siving the resident which has the potential for requiring on; age in the resident's physical, so is status (that is, a th, mental, or psychosocial hreatening conditions or s); realment significantly (that is, a sea existing form of verse consequences, or to the property of the property		P580- Notify of Changes (Injury/ Decline/Room etc.)  1. Resident #5 face sheet has be updated with the correct address of the Resident Representative on 12/05/20 Resident #7 discharged from facility 11/04/2019.  2. Quality Monitor of current facility residents to ensure face sheet reflect accurate addresses (mailing and email) and phone number of the resident representative, completed by the Director of Social Services and Social Services Assistant. Follow up based on findings	s nd

Any deficiency statement ending with an exterior (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other satisfuence provide artifician providing to the patients. (See instructions.) Except for surely homes, the findings stated above are disclosable 80 days following the date of servey whether or not a plan of correction is provided. For sureling homes, the above findings and plans of correction are declosable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program panticipation.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES  B. MEDICAID SERVICES			PRINTED. FORM	12/02/2019 APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIETUCLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	. 0938-0391 E SURVEY IPLETED
	PROVIDER OR BUPPLIER		B. WING	B 11	TREET ADDRESS, CITY, SYATS, ZIP CODE 017 GEORGE WASHINGTON HIGHWAY NORTH	C 21/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	atement of difficiencies Y must be preceded by Pull RC identifying information)	ID PREF TAG	KI	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 680	la available and prophysiolan.  (iii) The facility must resident and the rewhen there is.  (A) A change in rot as specified in §48 (B) A change in resident and regula (e)(10) of this section (iv) The facility musupdate the address phone number of trepresentative(s).  §483.10(g)(18) Admission to a contrat is a composite §483.10(g)(18) Admission to a contrat is a composite §483.5) must discill its physical configuity and must specific facility and must specific facility documental facility documental falled to ensure the address and or phrepresentative (RF survey sample (Resurvey	ation specified in \$463.15(c)(2) by ded upon request to the state opportunity the sident representative, if any, om or roommate assignment (3.10(e)(6); or sident rights under Federal or sident as specified in paragraph ion.  It record and periodically is (mailing and email) and the resident most in its admission agreement uration, including the various prise the composite distinct exity the policies that apply to ween its different locations in its different locations.  If and resident interviews, and then review, the facility staff by periodically updated the one number of the resident's stallents #5 and #7).	F	580	and Social Services Assistant reeducated by Director of Nursing ensuring that the residents face sheet is updated to reflect the current address (mailing and email) and phone number of the resident representative(s).  4. The Director of Social Services/Social Services Assistant/designee to conduct random quality monitoring of resident face sheets to ensure the address and phone number of resident representatives are updated/accurate 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings, 5. Allegation of Compliance 12/23/201	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					12/02/2019 MAPPROVED
		& MEDICAID SERVICES	-	5			0, 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDENSUPPLIER/CUA IDENTIFICATION NUMBER:	#0.000 (Contract Contract Cont		CONSTRUCTION	(X3) DA	TE SURVAY MPLETED
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NAME OF	PHOVIDER OR SUPPLIER	*	-		RET ADDRESS, CITY, STATE, ZIP CODE		(Z 1/2018
GREENE	IRIER REGIONAL ME	DICAL CENTER		50885A3-0000	7 GEORGE WASHINGTON HIGHWAY ESAPEAKE, VA 23923	NORTH	
(X4) ID PREFIX TAO	EACH DEFIGIRNOR	N'EMENT OF DEPICIENCIES Y MUST BE PRECEDED BY PULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	COMPLETION (MATE
F 680	And stroke.  The resident's most (MDS) assessment coded the resident score of 15 on the I status (BIMS) which intact with the necessarily.  Resident #5 had a was also her medicattomey, as well as sheet was not updated the RR.  On 11/21/19 at 11:2 with the Director of Assistant DSS, the correct address and care plan invitations as residents. They plan letters that had although they said received them because they called the RR.  a call back so they sheat with his correct address in the RR's address in the was in charge of the was in charge of the status of the residents.	amia, Type 2 diabetes mellitus  It recent Minimum Data Set  It was a quarterly dated 10/9/19  with a 15 out of a possible  Brisf Interview for Mental  In indicated the resident was  seary skills for dally decision  resident representative who  all and financial power of  emergency contact. The face  atted with the correct address of  20 a.m., during an interview  Social Services (DSS) and the  y stated all face sheets should  atted as needed with the dephone number. They stated as are mailed to families as well  could not produce any care depended to the RR  they knew the RR had  ause he came to visit dally and  clan meetings. They stated  on 11/20/19 and was awalting  could update the resident face  act address. The DSS stated  seded to be updated because  the affairs of Resident #5 and  ments other than care plan	F	580			
	On 11/21/19 at 2:50 the Administrator, 5	n, plus it was a requirement.  Dip.m., during a debriefing with Senior Administrator, ining. Director of Nursing					

		AND HUMAN SERVICES  & MEDICAID SERVICES				FOR	): 12/02/2019 APPROVED	
STATEMEN	T OF DEPIOIENCIES OF COARECTION	(X1) PROVIDER/BUPPLER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	CMB NO. 0936-0391	
12		495330	B. WING	í			C	
NAME OF	PROVIDER OR SUPPLIER	200 sq.	700	3TR	EET ADDRESS, CITY, STATE, ZIP CODE	!!	/21/2019	
GREEN	Brier regional me	DICAL CENTER	1017 George Washington Highway North Chebapeake, va 23323					
ix4i id Prefix Tag	! (EACH DEFICIENCY	NEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF YAC		Provider's Plan of Correc (Each Corrective action sho (Each Corrective action sho (Pobb-Referenced to the Appl Depiciency)	ULD BE	COMPLETION DATE	
F 580	(DON), the Regions aforementioned issention. No further the survey learn processing the survey learn processing facility 10/13/16, and resident #7's diagram assessment with a (ARD) of 8/18/19, completing the Bridge the Bridge the Bridge the survey with transfers, total locomotion, dreasing and bathing and lin with eating.  Resident #7's admitted the survey of the local discussed the policy and that the advanced directive the survey of the local dated 11/4/19, stall was to verify the remeat of kin but the provided by the nutries.	al DON and DSS, the size was brought to their information was presented to for to exit.  I originally admitted to the adward discharged from the nacute care hospital 11/4/19, noses included atrial fibrillation, a and dementia.  The Data Set (MDS) in assessment reference date coded the resident as of interview for Mental Status of out of a possible 15. This if 7's cognitive abilities for daily as severely impaired. In the part of the person with and functioning the resident alring total care of two people is care of one person with and, tolicting, personal hygiens, mited assistance of one person dated as the BiMS score as 7 out of a person with a series of the resident signed that she advanced directive-facility resident had not completed an		580				

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			Pi		12/02/2019	
		& MEDICAID SERVICES			Ö		APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED	
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NAME OF F	POVIDER OF BUPPLIER		BTARET ADDRESS, CITY, STATE, ZIP CODE					
GREENB	rier regional me	DICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323					
(X4) IO PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG OROS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			84	(RE) COMPLETION DATE	
F 580	didn't have contact member or anyone behalf of Resident nursing facility was additional informati management, the care were contacte regarding Resident next of kin contact. Review of the resident no address. The was documented a cheet completed upame for the emergaperoximately 2:45 she wasn't the ame member. The individual the resident to the name and phone in facility. The Individual the resident for the name and phone in facility would require the years the contacted her for vinformed them that afterney and neither explained the was deceased who was deceased.	se as a prior caregiver who information for a femily who could make decisions on #7. The provider stated the contacted and they had no on to offer therefore; risk ethics committee and patiative d to aid in making a decision #7's code status since no information was available.  Isn's face sheet revealed an 's name and phone number a relationship to the realdent is eon-in-law. The original face pon admission had the same gancy contact but the person infend,  onducted with the individual stated ergency contact on 11/20/19 at p.m., The Individual stated ergency contact or a family idual stated the resident ted living facility prior to nursing facility and she was a sident at the assisted living use stated she accompanied nursing facility's staff has arlous reasons and eite she wasn't the power of ar a relative. The individual is end the child's wife was	F	580				
		and the child's wife was and wite had only one child	!	i I I			9	

APITE	RS FOR MEDICARE	L MEDICAIN GEOVICES	PRINTED: 12/02/2019 FORM APPROVED OMB NO. 0938-0391					
	STATEMENT () POLITICISNOIFS (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION	(X3) DAT	E SURVEY		
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1000 1000 1000 1000 1000 1000 1000 100	PROVIDER OR SUPPLIER BRIER REGIONAL ME	DICAL CENTER		8TREET ADDRESS, CITY, STATE 1017 GEORGE WASHINGTON OHEBAPEAKE, VA 23323	E, ZIP CODE			
(X4) ID PREFIX TAG	! (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PREOGDED BY FULL AD IDENTIFYING INFORMATION)	ID PAGF TAG		OTHE APPROPRIATE	COMPLETION DATE		
F 58	Iname of the state of attorney and grawhen she had acciliving records the growled to the fact they have continue updating the record that she no longer resident's power of Review of the soci current in the clinic stating the resident other notes stated family didn't respond they call, care plan invited both didn't.  An interview was a p.m., with the Soc SSA stated she had years and she had visiting Resident if with anyone who is member, only the documented on the An interview was a p.m., with the Direct The DSS stated a facility in July 201 sheets and updatified. The DS number for Resident it to their bought it to their	and that person resided in and was the resident's power undeen. The individual stated see to the resident's assisted grandson's phone number was illty's staff but over the years of to call her instead of d. The individual made it clear had the phone number for the fattorney/grandson all service notes from 11/7/17 to cal receives support from family, resident's family visits often, and to care plan letter nor did in reviewed, resident and family.		680				

DEPART	MENT OF HEALT	HAND HUMAN SERVICES			PAINTED	12/02/2019	
		E & MEDICAID SERVICES				1 APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CONSECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION MUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X9) DATE SURVEY COMPLETED	
		485330	8 WING			C	
NAME OF	ROVIDER OR SUPPLIER			19	TREET ADDRESS, CITY, STATE, ZIP CODE	/21/2019	
GREENS	RIER REGIONAL M	EDICAL CENTER		1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(XA) ID PREFIX TAG	(EACH DEFICIENT	Tatement of deficiencies by must be preceded by full lsc identifying information)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORPECTION [EACH CORRECTIVE ACTION SHOULD BE GROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY]	COMPLETION DATE	
F 745	her the individual wasn't the resident wasn't the resident on 11/21/19, at a shove findings we Administrator, Directors of the consultant. An opticality to present was provided. Provision of Medic CFR(s): 483.40(d) S483.40(d) The famedically-related maintein the higher and psychosocial This REQUIREME by: Based on a compresord review, standoumentation revolute medically-identify and assist	so etated no one had informed on the resident's tace sheet of the resident's tace sheet of a responsible party or relative.  pproximately 2:50 p.m., the reshared with the actor of Nursing and the Nurse portunity was given for the additional information but none additional information but none cally Related Social Service collisty must provide social services to attain or set practicable physical, mental well-being of each resident. ENT is not met as evidenced of interviews, and facility view, the feolity stelf failed to related social services to 2 of 7 residents (Resident #8		745	F745- Provision of Medically Related Social Service  1. Resident #6, The Director of Social Services and Administrator met with a potential guardian on 12/4/2019 and has initiated the process for obtaining guardianship.  Resident #7 discharged from facility on 11/04/2019.		
	well-being.  The findings include	an advocate to maintain their			2. Quality Monitor of current facility residents to ensure each have an appropriate advocate/ Resident Representative, completed by the		
	diagnoses that inc depressive disord heart disease, atri	s admitted on 1/3/18 with cluded dementia, major er, delirium, anxiety disorder, al librillation, selzure disorder nusola weakness. The realdent il gode.			Director of Social Services /Social Services Assistant/designee. Follow up based on findings.		
		Ainimum Data Set (MDS) i 9/5/19 was an annual and					
CONTRACTOR OF THE RESIDENCE OF THE RESID				- 1	1	51	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	12/02/2019 APPROVED
TATEMENT	of deficiencies f cormection	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3) DAT	0936-039 E SURVEY PLETED
uille e-		495930	B. WING	- 1 75 <sup>2</sup> 5	11/	C 21/2019
	PROVIDER OR SUPPLIER PRIER REGIONAL ME	DICAL CENTER		14	Treet address, city, state, zip oods 317 George Washington Highway North Hesapeake, va 23323	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	tement of deficiencies - Must be preceded by full - Sc identifying information)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 745	coded the resident Brief Interview for hindicated the resident was a manifested in an in disorganized think!  The care areas the Care Area Assess 9/17/19 included confusion communication and incontinence, i psychotropic drug resident had obser included confusion communication and has occurred over incontinence, the dises. For psychiati major depression, anti-anxiety medico cognition.  The quarterly MDS coded the resident possible 15 which severely impaired decision making.  The quarterly MDS 1/16/19, and 11/10 BIMS as a 3 out of the resident was a needed for daily decision falls related to falls related to	with a 3 out of a 15 on the Mental Statua (BIMS) which ent was severely impaired in a for daily decision making.  It is esseed with delirium that ability to focus with ng.  It triggered in the resident's ment (CAA) Summary dated orgitive loss/dementia, ADLs falls, nutritional status and use. For cognitive loss, the vable characteristics that it is, discrientation, forgetfulness, discrientation forgetfulness in the state of a findicated was anti-anxiety with the use of a findicated the resident was in the skills needed for daily.  Sassessments dated 4/16/19, W18, coded the resident on the lapossible 15 which indicated everely impaired in the skills.		745	and Social Services Assistant reeducated by Director of Nursing to ensure residents have an advocate/resident representative in order to provide medically related social services to attain and maintain the highest practicable physical, mental and psychosocial well-being.  4. The Director of Social Services / Social Services Assistant/designee to conduct random quality monitoring through morning clinical meeting to ensure residents have an advocate/resident representative 3 x weekly x 2 weeks, 2 x weekly x 2 weeks then weekly and PRN as indicated.  Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings.  5. Allegation of Compliance 12/23/2019	

		HAND HUMAN SERVICES		P		12/02/2019 APPROVED		
		E & MEDICAID SERVICES		A STATE OF THE STA	MB NO.	0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	PERSONAL PROPERTY AND ADDRESS OF THE PARTY.	LE CONSTRUCTION	(K3) DATE SURVEY COMPLETED			
		495330	B. WING			0		
NAME OF	PROVIDER OR SUPPLIES	1		STREET ADDRESS, OITY, STATE, ZIP CODS	117	21/2019		
GREEN	PRIER REGIONAL M	edical center	1017 George Washington Highway North Chesapeake, va 29928					
(X4) ID PREPIX TAG	LEACH DEFICIENC	Tatement of Deficiencies Cy Must be precieded by Pull Lec Identifying Information)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	88	COMPLETION DATE		
F 745	The goal set by the free of injury. The identified the residentified the residentified the residentified the she would not have psychotropic drug resident was also the goal set by the injure herself as a care plan identified were to remain a staff was that they. The care plan date 9/4/19 as ourrent code. The goal se was that "My adverned the goal se was that "My adverned the set of these advance directive health care represented to the set of 11/20/19 at 11 observed observed the shower room. (CNA) #3 was will observation. The	e staff was she would remain to ours plan dated 9/19/19 dent had physical behaviors of cries, and is on psychotropic goal set by the staff was that m herself and be tree of related complications. The Identified to have seizures and a staff was that she would not result of seizure disorder. The dithat the resident's wishes full code and the goal of the would uphold her wishes.  Bed 1/3/19 and last revised on identified the resident as a full to by the staff for the resident and directives are in effect, and rections will be carried out in my advance directives on an augh my next review date. The aff would take to carry out ectives included "Discuss with me and/or appointed sentative. Notify physician to it capacity and certify capacity or cision making will be essessed seded and will invoke a health of representative if applicable."	F 745					

DEPART	MENT OF HEALT	HAND HUMAN SERVICES			Pi		12/02/2019
		E & MEDICAID SERVICES			O	FOHM NA RIM	APPROVED 0938-0391
STATEMENT	OF DEFIDIENCIES F COMRECTION	(X1) PROVIDER/BUPPLIER/CLIA IOGNYIPICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495330	B. WING				כ
NAME OF F	ROVIDER OR SUPPLIE		0. 11.110		STREET ADDRESS, CITY, STATE, ZIP CODE	11/3	21/2019
					io17 george washington highway no	0 <b>7</b> 1	
GREENE	RIER REGIONAL M	edical center		CHEBAPEAKE, VA 23323		run	
(X4) IO PREFIX TAG	(BACH DEFICIENC	Tatement of deficiencies By Must be preceded by full LBO identifying information)	ID PRÉF TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION DATE
F 745	Continued From page 10 ask the same of was assigned the that she was "consisted if anyone of CNA responded,"  On 1/20/19 at 1:31 conducted with the (DSS) and Social DSS stated she was resident, but had a station if anyone of who had 7 years at atted she had no since her admissioned ever attend indicated "Fleeide long-term care for from also indicate resident representation in the care for and 9/19/19 that is atted they read the regardless if she and there was no one to. The care included to sign the page plan me 6/11/19 indicated unable to sign the DSS stated the in DSS stated the income constituted the income constituted the income constituted the sign the page plan me 6/11/19 indicated unable to sign the DSS stated the income constituted the constitut	rage 9 puestion. CNA #8 said that she resident on a regular basis and fused most of the time." When ame to visit the resident, the if have never seen anyone."  D.p.m., an interview was a Director of Social Services Services Assistant (SSA). The resident which make the building as of it did not know much about the been asking at the nurses ever came to visit her. The SSA, as a social worker in the facility, of each anyone visit the resident on in 2018. Both of them stated with some information about the plan meetings, a family or ed. The resident was her own talive (RR).  D. p.m., in the presence of two he DSS presented the care plan ated 3/5/19, 4/30/19, 6/11/19 were given to the resident was able to understand them other person to have mailed the resident was able to understand them other person to have mailed plan meeting dated 9/19/19 did the resident was in altendance. eting dated 3/5/19, 4/30/19, the resident altended but was a altendance signature log. The terdisciplinary team would go to		745	DEFICIENCY)	THE TAXABLE TA	
		m to conduct the meetings. A cumentation by the SSA on	İ				l

		AND HUMAN SERVICES	PRINTED: 12/02/2019 FORM APPROVED					
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	·		0	OMB NO. 0938-0391		
AND PLAN	t of deficiencies of correction	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	12000 0002 0000 0000	ETIPLE CONSTRUCTION DING		COM	e survey Pleted	
		496330	B. WING	) <sub>1/1/1</sub>			C 21/2019	
NAME OF	PROVIDER OR SUPPLIER	3854 - 2854 - 28545 - 11		STREET ADDRESS, CITY, STATE, Z	P CODE	1111	WILLAL S	
GREENI	Brier Regional Me	DICAL CENTER		1017 GEORGE WASHINGTON HI CHESAPEAKE, VA 23323	GHWAY NO	HTH		
(X4) ID PREFIX TAG	(GAOH DEFICIENC)	Tement of deficiencies ( Must be preceded by Pull 90 identifying inpormation)	ID PREF TAG	IX BACH CORRECTIVE ACT	ION SHOULD HE APPROPI	BE	COMPLETION (X3)	
F 745	4/30/19 Indicated the Resuscitate" which sheet, nurse's note indicated the reside the reside the resident's advance of the resident's advance of the resident's advance of the resident's advance of the resident decisions about he they stated, "No not contrary to the carringlicated "the resident decisions about he they stated, "No not contrary to the carringlicated "the resident of the resident of	ne resident was a "Do Not was different from the face is and physician orders that ent was a "Full Code".  I above interview and along both stated they tell based on need age, declining health, inability to make rational inhealthcare, they needed to a legal guardian for her. When it would be able to make it wishes to remain a full code, it likely." This statement was a plan dated 9/4/19 that lent wishes were to remain a coal of the staif was that they where. They relievated that no city, ever visited the resident in to the nursing facility and adge of the resident having to assist to make any decisions stated there was no policy in now where to begin to etart the less and said, "It needs to be e." They stated they would esk that the process was and	F	745				

ONM CM3-2667(02-39) Previous Versions Obsulete

Gvent ID, WK7411

Faulley ID: VA0043

If continuation sheet Page 11 of 15



		AND HUMAN SERVICES  & MEDICAID SERVICES				FOR	D: 12/02/2019 MAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/BUPPLIERCLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(K3) DA	D. 0938-0391 TE SURVEY MPLETED
		495330	B, WING	<b>.</b>		44	C /21/2019
NAME OF	HOVIDER OR SUPPLIER			1	STREET ADDRESS, DITY, STATE, ZIP CODE		1/2/12014
GREENE	RIER REGIONAL ME	DICAL CENTER			1017 George Washington Highway N Chesapeake, va 23323	MATH	
(X4) ID PREPIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  BO IDENTIFYING INFORMATION;	ID PREF	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LORE	COMPLETION DATE
F 745	was brought to the Senlor Administrator Director of Nursing that all social service dated \$/2/18, 6/6/18 6/6/19, 9/10/19 and same entry by the Supportive as well a Administrator state inaccurate information was proceed and the service of the serv	D.p.m., during the debrieting, it attention of the Administrator, attention of the Administrator, or, Administrator in training, (DON) and Regional and D89 ses progress notes reviewed 8, 11/13/18, 1/16/19, 4/16/19, 11/19/19 had the following SSA: "Resident's family is as staff and volunteers." The dishe would be addressing the tion with the SSA. No turther ovided prior to survey exit. It originally admitted to the adward discharged from the nacute care hospital 11/4/19.		745			

advanced directive.

CENTER	MENT OF HEALTH	AND HUMAN SERVICES  MEDICAID SERVICES			· · · · · · · · · · · · · · · · · · ·	FORM	12/02/2019 APPROVED 0938-0391
BTATEMENT	OF DEFICIENCIES F CORRECTION	(K1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	12 5000 0000		CONSTRUCTION	(X9) DAT COM	e survey IPLGTED
		495330	8, WING	<u> </u>		1 20 0	C 21/2019
NAME OF F	ROVIDER OF SUPPLIER		<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 11/	21/2018
GREEND	RIER REGIONAL ME	DICAL CENTER			7 GEORGE WASHINGTON HIGHWAY N ESAPEAKE, VA 23323	ОЯТН	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SO IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DHE	(X6) COMPLETION DATE
F 745	#7 was unable to retime of her admiss review of the resident had an includer the title was demergency contact. Review of a physical 11/1/19 at 3:10 p.n. was seking the physical domen and polyunable to provide the further stated the resident of kin but the provided by the number of kin but the provided by the number of kin but the provided by the number or anyone dentified themselved in the provided of Resident nursing facility was the selection of the selection	pai record revealed Resident nake sound decisions at the lon to the facility 10/2016, Also ant's face sheet revealed the dividual listed as a friend and hanged to a son in jaw as a		746			
	management, the care were contacte regarding Residen next of kin contact	alhics committee and palilative and to aid in making a decision the status since no information was available.					
	p.m., with the Sool SSA stated based e CMIB bas suiste	onduoted 11/20/19, at 12:30 al Sarvice Assistant (SSA). The on the resident's cognitive core she didn't fael the resident king a decision regarding a	NILL.				1

		H AND HUMAN SERVICES LE & MEDICAID SERVICES			FOR	M APPROVED
BTATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	107 10	IPLE CONSTRUCTION		O. 0938-0391 ATE BURVEY OMPLETED
485330			B. WING _		C	
NAME OF	NAME OF PROVIDER OR BUPPLIER			STREET ADDRESS, CITY, BYATE, ZIP CODE	11/21/2019	
GREENS	RIBA REGIONAL M	EDICAL CENTER	21	1017 GEORGE WASHINGTON HIGHWAY CHESAPEAKE, VA 23923	NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES BY MUST BE PRECECED BY FULL LBO IDENTIPYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROBS-REFERENCED TO THE APPI DEPICIENCY)	ULO BE	(XE) COMPLETION DATE
F 745	Cat scan or the or a legal representation as the emergence of the care of the contacted her for informed them the attorney and neith further explained the who was decease of the contacted the contacted of the care of the c	rage 13 and for such reasons alive was necessary.  conducted with the individual gency contact on 11/20/19 at 5 p.m., the individual stated she ency contact or a family vidual stated the resident stated living facility prior to nursing facility and she was a seldent at the assisted living facility and left her number in the event the nursing facility and left her number in the event the nursing facility. The Individual stated onursing facility's etaff has various reasons and she at she wasn't the power of the resident had only one child d and the child's wife was and wife had only one child in and that person realded in	F 74	45		
	(name of the state of attorney and growth she had acceptiving reports the provided to the fact they have continuing updating the record them. The individual	and was the resident's power andson. The individual elated sess to the resident's assisted grandson's phone number was cillly's staff but over the years ed to call her instead of ord with the number provided to sall made it clear that she no one number for the regident's				:
	p.m., with the Dire (DSS). The DSS a	conducted 11/20/18, at 3:20 setor of Social Services Director stated since she began working by 2019, they were reviewing				]

if continuation shoot Page 16 of 16

DEPART	IMENT OF HEALTH RS FOR MEDICARI	HAND HUMAN SERVICES E & MEDICAID SERVICES				RINTED: 12/02/20 FORM APPROVE		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SLIPP		(X1) PROVIDER/SUPPLIER/CLIA IDENT/FICATION NUMBER:	A INSTALLATION & CONCERNATION			OMB NO. 0936-03: (X3) DAYR BURVEY COMPLETED		
		495330	B. WING	Throat is provided to determine the		С		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS. CIT	V STATE ZIP OODE	11/21/2019		
GREENE	HIN REGIONAL MI	POICA) CENTED	*		INGTON HIGHWAY NO	2TH		
		1000 Various words;		CHEGAPEAKE, VA				
(X4) ID PREFIX TAG	(BACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST 35 PRECEDED BY FULL LSC IDENTIFYING INPORMATION)	IQ PARA TAG	X   (EACH CORR	'S PI.AN OF CORRECTION ECTIVE ACTION BHOULD ENCED TO THE APPROPR DEFICIENCY)	COMPLETED		
	not been identified team brought it to a stated in the event good decisions it were possible party dinformed her the in sheet wasn't the reparty/relative or leg. The Administrator approximately 3:20 policy is if a resident decisions and does next of kin to make would contact a local date and request a for the resident.  On 11/21/19, at appeabove findings were Administrator, Directonsultant. An opping the possibility of the consultant.	dating them as concerns were stated they had a phone of #7 but no address. This had as a concern until the survey our attention. The DSS also a resident was unable to make yould be necessary to have a saignated but no one had dividual on the resident's face aldent's responsible saf representative.  Stated on 11/20/19, at p.m., the facility's unwritten on isn't capable of making on't have a responsible party or idecision on their behalf we sail legal counsel, obtain a court legal guardian be appointed	F 7	46				
DON OMS-200	7(02-99) Provious Versions	Obsoleje Evuni ID;WK2011		Pagility ID: VAQD49	If continue to			

Pacifity ID: VA0043

