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

PRINTED: 12/02/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495330	A. BUILDING _____ B. WING _____	C 11/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREENBRIER REGIONAL MEDICAL CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 11/19/19 through 11/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. The census in this 120 certified bed facility was 107 at the time of the survey. The survey sample consisted of 7 current Residents reviews (Residents #1 through #6) and 1 closed record review (Resident #7).	F 000	000 This plan of correction is respectfully submitted in response to deficiencies cited on November 19-21, 2019 complaint survey. This plan of correction constitutes a written allegation of substantial compliance with the Federal Medicare and Medicaid requirements. The submission of this plan of correction does not constitute an agreement that the deficiencies exist, nor is it an admission that they existed. It is an expression of the Facilities desire to fully comply with the Medicare and Medicaid requirements.	
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(16) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE EP / LNHA | (X6) DATE 12/11/19

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

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F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that	F 580	F580- Notify of Changes (Injury/ Decline/Room etc.) 1. Resident #5 face sheet has been updated with the correct address of the Resident Representative on 12/05/2019. Resident #7 discharged from facility on 11/04/2019. 2. Quality Monitor of current facility residents to ensure face sheets 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	12/23/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: ED / LNHA — (X6) DATE: 12/11/19

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F 580	Continued From page 1 all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(18) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff and resident interviews, and facility documentation review, the facility staff failed to ensure they periodically updated the address and or phone number of the resident's representative (RR) for 2 of 7 residents in the survey sample (Residents #5 and #7). The findings included: 1. Resident #5 was admitted to the nursing facility on 8/30/14 with diagnoses that included high	F 580	3. The Director of Social Services and Social Services Assistant re-educated 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 12/23/2019	

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F 580	Continued From page 2 blood pressure, anemia, Type 2 diabetes mellitus and stroke. The resident's most recent Minimum Data Set (MDS) assessment was a quarterly dated 10/9/19 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was intact with the necessary skills for daily decision making. Resident #5 had a resident representative who was also her medical and financial power of attorney, as well as emergency contact. The face sheet was not updated with the correct address of the RR. On 11/21/19 at 11:20 a.m., during an interview with the Director of Social Services (DSS) and the Assistant DSS, they stated all face sheets should be reviewed and updated as needed with the correct address and phone number. They stated care plan invitations are mailed to families as well as residents. They could not produce any care plan letters that had been mailed to the RR although they said they knew the RR had received them because he came to visit daily and attended the care plan meetings. They stated they called the RR on 11/20/19 and was awaiting a call back so they could update the resident face sheet with his correct address. The DSS stated the RR's address needed to be updated because he was in charge of the affairs of Resident #5 and there may be documents other than care plan letters to mail to him, plus it was a requirement. On 11/21/19 at 2:50 p.m., during a debriefing with the Administrator, Senior Administrator, Administrator in training, Director of Nursing	F 580		

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F 580	Continued From page 3 (DON), the Regional DON and DS6, the aforementioned issue was brought to their attention. No further information was presented to the survey team prior to exit. 2. Resident #7 was originally admitted to the facility 10/13/16, and was discharged from the nursing facility to an acute care hospital 11/4/19. Resident #7's diagnoses included atrial fibrillation, Parkinson's disease and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/16/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making was severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, total care of one person with locomotion, dressing, toileting, personal hygiene, and bathing and limited assistance of one person with eating. Resident #7's admission MDS assessment dated 10/20/16 also coded the BIMS score as 7 out of a possible 15. Further review of the clinical record revealed on 10/13/16 the resident signed that she has discussed the advanced directive facility policy and that the resident had not completed an advanced directive. Review of the local acute care hospital notes dated 11/4/19, stated the provider's biggest goal was to verify the resident's code status with the next of kin but the emergency contact information provided by the nursing facility wasn't an emergency contact. The individual contacted	F 580		

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F 580	Continued From page 4 identified themselves as a prior caregiver who didn't have contact information for a family member or anyone who could make decisions on behalf of Resident #7. The provider stated the nursing facility was contacted and they had no additional information to offer therefore; risk management, the ethics committee and palliative care were contacted to aid in making a decision regarding Resident #7's code status since no next of kin contact information was available. Review of the resident's face sheet revealed an emergency contact's name and phone number but no address. The relationship to the resident was documented as son-in-law. The original face sheet completed upon admission had the same name for the emergency contact but the person was identified as a friend. An interview was conducted with the individual listed as the emergency contact on 11/20/19 at approximately 2:45 p.m., The individual stated she wasn't the emergency contact or a family member. The individual stated the resident resided at an assisted living facility prior to transferring to the nursing facility and she was a caregiver to the resident at the assisted living facility. The individual stated she accompanied the resident to the nursing facility and left her name and phone number in the event the nursing facility would require additional information from the assisted living facility. The individual stated over the years the nursing facility's staff has contacted her for various reasons and she informed them that she wasn't the power of attorney and neither a relative. The individual further explained the resident had only one child who was deceased and the child's wife was deceased, the son and wife had only one child	F 580		

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F 580	Continued From page 5 (name of the child) and that person resided in (name of the state) and was the resident's power of attorney and grandson. The individual stated when she had access to the resident's assisted living records the grandson's phone number was provided to the facility's staff but over the years they have continued to call her instead of updating the record. The individual made it clear that she no longer had the phone number for the resident's power of attorney/grandson Review of the social service notes from 11/7/17 to current in the clinical record revealed notes stating the resident receives support from family, other notes stated resident's family visits often, family didn't respond to care plan letter nor did they call, care plan reviewed, resident and family invited both didn't attend. An interview was conducted 11/19/19, at 2:30 p.m., with the Social Service Assistant (SSA). The SSA stated she had worked at the facility seven years and she had never heard of any family visiting Resident #7 and she had never spoken with anyone who identified themselves as a family member, only the emergency contact documented on the resident's face sheet. An interview was conducted 11/20/19, at 3:20 p.m., with the Director of Social Services (DSS). The DSS stated since she began working at the facility in July 2019, they were reviewing face sheets and updating them as concerns were identified. The DSS stated they had a phone number for Resident #7 but no address. This had not been identified as a concern until survey team brought it to their attention. The DSS stated it was important to have addresses so they could mail information and documents to the responsible	F 580		

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F 580	Continued From page 6 party. The DSS also stated no one had informed her the individual on the resident's face sheet wasn't the resident's responsible party or relative. On 11/21/19, at approximately 2:50 p.m., the above findings were shared with the Administrator, Director of Nursing and the Nurse Consultant. An opportunity was given for the facility to present additional information but none was provided.	F 580		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on a complaint investigation, clinical record review, staff interviews, and facility documentation review, the facility staff failed to provide medically-related social services to identify and assist 2 of 7 residents (Resident #6 and #1) to obtain an advocate to maintain their well-being. The findings include: 1. Resident #6 was admitted on 1/3/18 with diagnoses that included dementia, major depressive disorder, delirium, anxiety disorder, heart disease, atrial fibrillation, seizure disorder and generalized muscle weakness. The resident was currently a full code. The most recent Minimum Data Set (MDS) assessment dated 9/5/19 was an annual and	F 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. 2. Quality Monitor of current facility residents to ensure each have an appropriate advocate/ Resident Representative, completed by the Director of Social Services /Social Services Assistant/designee. Follow up based on findings.	12/23/19

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F 745	Continued From page 7 coded the resident with a 3 out of a 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the necessary skills for daily decision making. The resident was assessed with delirium that manifested in an inability to focus with disorganized thinking. The care areas that triggered in the resident's Care Area Assessment (CAA) Summary dated 9/17/19 included cognitive loss/dementia, ADLs and incontinence, falls, nutritional status and psychotropic drug use. For cognitive loss, the resident had observable characteristics that included confusion, disorientation, forgetfulness, communication and a decrease in cognition that has occurred over time. For ADLs and incontinence, the decline was related to cognitive loss. For psychiatric area, the reason listed was major depression, anti-anxiety with the use of anti-anxiety medication and a decrease in cognition. The quarterly MDS assessment dated 6/6/19 coded the resident on the BIMS as a 4 out of a possible 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The quarterly MDS assessments dated 4/16/19, 1/16/19, and 11/10/18, coded the resident on the BIMS as a 3 out of a possible 15 which indicated the resident was severely impaired in the skills needed for daily decision making. The care plan dated 10/29/19 identified the resident had actual falls and was at continued risk for falls related to psychoactive drug use, seizure disorders, deconditioning and vision problems.	F 745	3. The Director of Social Services and Social Services Assistant re-educated 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	

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F 745	Continued From page 8 The goal set by the staff was she would remain free of injury. The care plan dated 9/19/19 identified the resident had physical behaviors of hitting herself and cries, and is on psychotropic medications. The goal set by the staff was that she would not harm herself and be free of psychotropic drug related complications. The resident was also identified to have seizures and the goal set by the staff was that she would not injure herself as a result of seizure disorder. The care plan identified that the resident's wishes were to remain a full code and the goal of the staff was that they would uphold her wishes. The care plan dated 1/3/19 and last revised on 9/4/19 as current identified the resident as a full code. The goal set by the staff for the resident was that "My advance directives are in effect, and my wishes and directions will be carried out in accordance with my advance directives on an ongoing basis through my next review date." The approaches the staff would take to carry out these advance directives included "Discuss advance directives with me and/or appointed health care representative. Notify physician to assess my mental capacity and certify capacity or incapacity. My decision making will be assessed quarterly and as needed and will invoke a health care agent or legal representative if applicable." There were no advance directives for Resident #6 presented to the survey team. On 11/20/19 at 11:50 a.m., Resident #6 was observed observed in a geri-lounger type chair in the shower room. Certified Nursing Assistant (CNA) #3 was with the resident during this observation. The resident repeatedly asked this surveyor, "Who you are?" This surveyor responded each time, but the resident continued	F 745		

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F 745	Continued From page 9 to ask the same question. CNA #6 said that she was assigned the resident on a regular basis and that she was "confused most of the time." When asked if anyone came to visit the resident, the CNA responded, "I have never seen anyone." On 1/20/19 at 1:30 p.m., an interview was conducted with the Director of Social Services (DSS) and Social Services Assistant (SSA). The DSS stated she was new to the building as of January 2019 and did not know much about the resident, but had been asking at the nurses station if anyone ever came to visit her. The SSA, who had 7 years as a social worker in the facility, stated she had not seen anyone visit the resident since her admission in 2018. Both of them stated they would return with some information about whether during care plan meetings, a family or friend ever attended. The resident's face sheet indicated "Resident is self responsible." The long-term care facility the resident transferred from also indicated the resident was her own resident representative (RR). On 1/20/19 at 2:15 p.m., in the presence of two other surveyors, the DSS presented the care plan invitation letters dated 3/5/19, 4/30/19, 6/11/19 and 9/19/19 that were given to the resident. She stated they read the letters to the resident regardless if she was able to understand them and there was no other person to have mailed one to. The care plan meeting dated 9/19/19 did not evidence that the resident was in attendance. The care plan meeting dated 3/5/19, 4/30/19, 6/11/19 indicated the resident attended but was unable to sign the attendance signature log. The DSS stated the interdisciplinary team would go to the resident's room to conduct the meetings. A discrepancy in documentation by the SSA on	F 745		

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	496330	A. BUILDING _____ B. WING _____	C 11/21/2019

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F 745	Continued From page 10 4/30/19 indicated the resident was a "Do Not Resuscitate" which was different from the face sheet, nurse's notes and physician orders that indicated the resident was a "Full Code". The SSA joined the above interview and along with the DSS, they both stated they felt based on the resident's advanced age, declining health, poor cognition with inability to make rational decisions about her healthcare, they needed to consider obtaining a legal guardian for her. When asked if the resident would be able to make decisions about her wishes to remain a full code, they stated, "No not likely." This statement was contrary to the care plan dated 9/4/19 that indicated "the resident wishes were to remain a full code and the goal of the staff was that they would uphold her wishes". They reiterated that no one, to include family, ever visited the resident since her admission to the nursing facility and they had no knowledge of the resident having anyone to be able to assist to make any decisions for her. They also stated there was no policy in place for them to know where to begin to start the guardianship process and said, "It needs to be done for her welfare." They stated they would ask the Administrator what the process was and would get back to the survey team. On 11/20/19 at 3:20 p.m., an interview was conducted with the Administrator, DSS and SSA. The Administrator stated there was no printed policy in place, but he consulted with his professional colleagues and said the process to follow to obtain legal guardianship for a resident included contacting local legal counsel and set a court date to have a court appointed legal guardian.	F 745		

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F 745	Continued From page 11 On 11/21/19 at 2:50 p.m., during the debriefing, it was brought to the attention of the Administrator, Senior Administrator, Administrator in training, Director of Nursing (DON) and Regional and DBS that all social services progress notes reviewed dated 5/2/18, 6/6/18, 11/13/18, 1/16/19, 4/16/19, 6/6/19, 9/10/19 and 11/19/19 had the following same entry by the SSA: "Resident's family is supportive as well as staff and volunteers." The Administrator stated he would be addressing the inaccurate information with the SSA. No further information was provided prior to survey exit. 2. Resident #7 was originally admitted to the facility 10/13/16, and was discharged from the nursing facility to an acute care hospital 11/4/19. Resident #7's diagnoses included atrial fibrillation, Parkinson's disease and dementia. The quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 8/18/19, coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 7 out of a possible 15. This indicated Resident #7's cognitive abilities for daily decision making was severely impaired. In section "G" (Physical functioning) the resident was coded as requiring total care of two people with transfers, total care of one person with locomotion, dressing, toileting, personal hygiene, and bathing and limited assistance of one person with eating. Resident #7's admission MDS assessment dated 10/20/16 also coded the BIMS score as 7 out of a possible 15. Further review of the clinical record revealed on 10/13/16 the resident signed that she has discussed the advanced directive facility policy and that the resident had not completed an advanced directive.	F 745		

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F 745	Continued From page 12 Review of the clinical record revealed Resident #7 was unable to make sound decisions at the time of her admission to the facility 10/2016. Also review of the resident's face sheet revealed the resident had an individual listed as a friend and later the title was changed to a son in law as a emergency contact. Review of a physician's message log dated 11/1/19 at 3:10 p.m., revealed the facility's nurse was asking the physician if his intention was to send the resident out for a Cat scan of the abdomen and pelvis for the mobile services were unable to provide the ordered test. The note further stated the resident does not wish to go. Review of the local acute care hospital notes dated 11/4/19, stated the provider's biggest goal was to verify the resident's code status with the next of kin but the emergency contact information provided by the nursing facility wasn't an emergency contact because the individual identified themselves as a prior caregiver who didn't have contact information for a family member or anyone who could make decisions on behalf of Resident #7. The provider stated the nursing facility was contacted and they had no additional information to offer therefore, risk management, the ethics committee and palliative care were contacted to aid in making a decision regarding Resident #7's code status since no next of kin contact information was available. An interview was conducted 11/20/19, at 12:30 p.m., with the Social Service Assistant (SSA). The SSA stated based on the resident's cognitive status and BIMS score she didn't feel the resident was capable of making a decision regarding a	F 745		

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F 745	Continued From page 13 Cat scan or the code status and for such reasons a legal representative was necessary. An interview was conducted with the individual listed as the emergency contact on 11/20/19 at approximately 2:45 p.m., the individual stated she wasn't the emergency contact or a family member. The individual stated the resident resided at an assisted living facility prior to transferring to the nursing facility and she was a caregiver to the resident at the assisted living facility. The individual stated she accompanied the resident to the nursing facility and left her name and phone number in the event the nursing facility would require additional information from the assisted living facility. The individual stated over the years the nursing facility's staff has contacted her for various reasons and she informed them that she wasn't the power of attorney and neither a relative. The individual further explained the resident had only one child who was deceased and the child's wife was deceased, the son and wife had only one child (name of the child) and that person resided in (name of the state) and was the resident's power of attorney and grandson. The individual stated when she had access to the resident's assisted living records the grandson's phone number was provided to the facility's staff but over the years they have continued to call her instead of updating the record with the number provided to them. The individual made it clear that she no longer had the phone number for the resident's power of attorney/grandson. An interview was conducted 11/20/19, at 3:20 p.m., with the Director of Social Services Director (DSS). The DSS stated since she began working at the facility in July 2019, they were reviewing	F 745		

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F 745	Continued From page 14 face sheets and updating them as concerns were identified. The DDS stated they had a phone number for Resident #7 but no address. This had not been identified as a concern until the survey team brought it to our attention. The DSS also stated in the event a resident was unable to make good decisions it would be necessary to have a responsible party designated but no one had informed her the individual on the resident's face sheet wasn't the resident's responsible party/relative or legal representative. The Administrator stated on 11/20/19, at approximately 3:20 p.m., the facility's unwritten policy is if a resident isn't capable of making decisions and doesn't have a responsible party or next of kin to make decision on their behalf we would contact a local legal counsel, obtain a court date and request a legal guardian be appointed for the resident. On 11/21/19, at approximately 2:50 p.m., the above findings were shared with the Administrator, Director of Nursing and the Nurse Consultant. An opportunity was given for the facility to present additional information but none was provided.	F 745		