	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495330	B. WING		07/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	
				1017 GEORGE WASHINGTON HIGHW	AY NORTH
GREENBF	IER REGIONAL MEDI	CAL CENTER		CHESAPEAKE, VA 23323	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	
PREFIX TAG	•	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE DATE
E 000	Initial Comments		E OC	00	
E 006	survey was conduct 07-22-21. Correctin compliance with 42 Requirement for Loc emergency prepare investigated during	ong-Term Care Facilities. No edness complaint(s) were	E 00	06	
SS=C	§460.84(a)(1)-(2), § (1)-(2), §483.475(a §485.68(a)(1)-(2), § §485.727(a)(1)-(2),	§416.54(a)(1)-(2), §441.184(a)(1)-(2), §482.15(a)(1)-(2), §483.73(a))(1)-(2), §484.102(a)(1)-(2),			
	and maintain an en that must be review 2 years. The plan	n. The [facility] must develop nergency preparedness plan ved, and updated at least every must do the following:]			
	facility-based and o	d include a documented, community-based risk ng an all-hazards approach.*			
		es for addressing emergency / the risk assessment.			
	The Hospice must emergency prepare reviewed, and upda plan must do the fo	§418.113(a):] Emergency Plan. develop and maintain an edness plan that must be ated at least every 2 years. The illowing: id include a documented,			

08/24/2021

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.

		D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE		
		495330	B. WING			07/	22/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	-	
GREENBF	RIER REGIONAL MEDICA				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323	IWAY NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE		
E 006	facility-based and cor assessment, utilizing (2) Include strategies events identified by the including the manage of power failures, natule emergencies that would ability to provide care *[For LTC facilities at Plan. The LTC facilities at Plan. The LTC facility an emergency prepar reviewed, and update must do the following (1) Be based on and if facility-based and cor assessment, utilizing including missing resi (2) Include strategies events identified by the *[For ICF/IIDs at §483] The ICF/IID must dev emergency prepared reviewed, and update plan must do the follo (1) Be based on and if facility-based and cor assessment, utilizing including missing client (2) Include strategies events identified by the This REQUIREMENT by: Based on record revis facility staff failed to exprepared preparedness plan was	nmunity-based risk an all-hazards approach. for addressing emergency he risk assessment, ment of the consequences ural disasters, and other ald affect the hospice's §483.73(a):] Emergency must develop and maintain edness plan that must be d at least annually. The plan c include a documented, nmunity-based risk an all-hazards approach, dents. for addressing emergency he risk assessment. 8.475(a):] Emergency Plan. elop and maintain an hess plan that must be d at least every 2 years. The wing: nclude a documented, nmunity-based risk an all-hazards approach, net least every 2 years. The wing: nclude a documented, nmunity-based risk an all-hazards approach, nts. for addressing emergency	E	006				

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PRINTED: 11/18/2021

		D HUMAN SERVICES			FORM	D: 11/18/2021 MAPPROVED		
STATEMENT C	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	D. 0938-0391 SURVEY PLETED		
		495330	B. WING		07/	22/2021		
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GREENBR	RIER REGIONAL MEDICA	L CENTER	1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE		
E 006	Continued From page	2	E 00	06				
	The findings included	:						
	The facility's Emerger dated April 1, 2019.	ncy Preparedness plan was						
	2019. The risk assess for epidemic and infe	indicated a date of May 31, sment did not include data ctions. The risk assessment 8 on a scale of 10 with zero						
	facility's risk assessm administrator stated, ' the emergency prepa	ormation based on the ent, the interim 'The facility had not updated redness plan."						
E 036 SS=C	0	ng	E 03	36				
	§403.748(d), §416.54 §441.184(d), §460.84 §483.475(d), §484.10 §485.625(d), §485.72 §486.360(d), §491.12	(d), §482.15(d), §483.73(d), 2(d), §485.68(d), 7(d), §485.920(d),						
	Hospice at §418.113, at §460.84, Hospitals §484.102, CORFs at "Organizations" under §485.920, OPOs at §4	§485.68, CAHs at §486.625, r 485.727, CMHCs at 486.360, and RHC/FHQs at and testing. The [facility]						
	based on the emerger paragraph (a) of this s	and testing program that is ncy plan set forth in section, risk assessment at is section, policies and						

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 11/18/2021 M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495330	B. WING		07	/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA			1017 GEORGE WASHINGTON HIGHWAY N CHESAPEAKE, VA 23323	ORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 036	procedures at paragra the communication pl section. The training be reviewed and upda *[For LTC facilities at and testing. The LTC maintain an emergend and testing program t emergency plan set fo section, risk assessm this section, policies at (b) of this section, and paragraph (c) of this set testing program must least annually. *[For ICF/IIDs at §483 testing. The ICF/IID m an emergency prepar program that is based forth in paragraph (a) assessment at paragr policies and procedur section, and the comm paragraph (c) of this set testing program must least every 2 years. T requirements for evac §483.470(i). *[For ESRD Facilities testing, and orientation develop and maintain preparedness training orientation program the	aph (b) of this section, and an at paragraph (c) of this and testing program must ated at least every 2 years. §483.73(d):] (d) Training facility must develop and cy preparedness training hat is based on the orth in paragraph (a) of this ent at paragraph (a)(1) of and procedures at paragraph d the communication plan at section. The training and be reviewed and updated at 8.475(d):] Training and nust develop and maintain redness training and testing d on the emergency plan set of this section, risk raph (a)(1) of this section, res at paragraph (b) of this munication plan at section. The training and be reviewed and updated at the ICF/IID must meet the cuation drills and training at at §494.62(d):] Training, m. The dialysis facility must an emergency g, testing and patient	E 036			

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DICAID SERVICES					D: 11/18/2021 MAPPROVED D. 0938-0391	
PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í				E SURVEY PLETED	
495330	B. WING			07/	/22/2021	
			STREET ADDRESS, CITY, STATE, ZIP CODE			
ENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323	HWAY NORTH		
ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
brocedures at paragraph e communication plan at on. The training, testing nust be evaluated and not met as evidenced and staff interview, the an emergency gram based on the /21/21 at 11: 56 A.M. ator, he was asked for and testing program in risk assessment or five current staff. The not able to provide and testing information cated a date of May 31, nt did not include data is. The risk assessment a scale of 10 with zero lness plan was dated d for the updated risk the interim administrator review and update the						
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495330 ENTER ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION) Procedures at paragraph e communication plan at on. The training, testing nust be evaluated and not met as evidenced and staff interview, the an emergency gram based on the /21/21 at 11: 56 A.M. ator, he was asked for and testing program in risk assessment or five current staff. The not able to provide and testing information eated a date of May 31, nt did not include data s. The risk assessment of a scale of 10 with zero	DICAID SERVICES PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MUL A. BUILD 495330 B. WING ENTER ID ENT OF DEFICIENCIES ST BE PRECEDED BY FULL SENTIFYING INFORMATION) PREF TAG Concedures at paragraph e communication plan at on. The training, testing nust be evaluated and not met as evidenced ID and staff interview, the an emergency gram based on the ID /21/21 at 11: 56 A.M. ator, he was asked for and testing program in risk assessment or five current staff. The not able to provide and testing information ID cated a date of May 31, nt did not include data s. The risk assessment or a scale of 10 with zero Iness plan was dated d for the updated risk the interim administrator review and update the E	DicAID SERVICES (X2) MULTIP PROVIDER/SUPPLIER/CLIA (X2) MULTIP LIDENTIFICATION NUMBER: A. BUILDING 495330 B. WING ENTER ID ENT OF DEFICIENCIES ID ST BE PRECEDED BY FULL PREFIX DENTIFYING INFORMATION) PREFIX Decommunication plan at on. The training, testing nust be evaluated and not met as evidenced E 03 And staff interview, the an emergency gram based on the ////////////////////////////////////	PROVDERSUPPLIERCLIA (22) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING 495330 B. WING ENTER IT GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 2323 ENT OF DEFICIENCIES ID PREFIX ENT OF DEFICIENCIES ID PREFIX CROSS-REFERENCED TO THILL UNIT GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 2323 ENT OF DEFICIENCIES ID PREFIX CROSS-REFERENCED TO THE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY Dorocedures at paragraph communication plan at on. The training, testing nust be evaluated and not met as evidenced And staff interview, the an emergency gram based on the /21/21 at 11: 56 A.M. tator, he was asked for and testing program in risk assessment or five current staff. The not able to provide and testing information rated a date of May 31, nt did not include data s. The risk assessment is a scale of 10 with zero hess plan was dated di for the updated risk he interim administrator review and update the E 037	Description Description PROVIDENSUPPLIERCLIA IDENTIFICATION NUMBER: (P2) MULTIPLE CONSTRUCTION A BUILDING (P3) DATE (P3) DATE A BUILDING 495330 B. WING 07. ENTER STREET ADDRESS, CITY, STATE, ZIP CODE 07. ENTER Intrace washingtony highway NORTH CHESAPEAKE, VA 23323 07. ENTER DEFOCENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 07. ENTER Intrace washingtony highway NORTH CHESAPEAKE, VA 23323 07. ENTER DEFOCENCIES STREET ADDRESS, CITY, STATE, ZIP CODE 07. Constructive addressing information PROVIDENT ADDRESS PLAN OF CORRECTION Take a second on the PROVIDENT ADDRESS PLAN OF CORRECTION ADDRESS STREET ADDRESS, CITY, STATE, ZIP CODE 2/21/21 at 11: 56 A.M. and testing information E 036 03. 2/21/21 at 11: 56 A.M. and testing information A staff interview, the and testing information 07. and testing information E 036 0. 0. <t< td=""></t<>	

Event ID: KQNC11

Facility ID: VA0043

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	MENT OF HEALTH AN	ID HUMAN SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		495330	B. WING			07/:	22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA				017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 037	 §441.184(d)(1), §460. §483.73(d)(1), §483.4 §485.68(d)(1), §485.4 §485.920(d)(1), §485.4 §485.920(d)(1), §486.4 *[For RNCHIs at §403 Hospitals at §482.15, at §484.102, "Organiz OPOs at §486.360, R (1) Training program. the following: (i) Initial training in err policies and procedur staff, individuals provia arrangement, and vol expected roles. (ii) Provide emergence least every 2 years. (iii) Maintain documer preparedness training (iv) Demonstrate staff procedures. (v) If the emergency p procedures are signiff must conduct training procedures. *[For Hospices at §41 hospice must do all of (i) Initial training in err policies and procedur hospice employees, a services under arrang expected roles. (ii) Demonstrate staff procedures. 	.84(d)(1), §482.15(d)(1), .75(d)(1), §484.102(d)(1), .625(d)(1), §485.727(d)(1), .360(d)(1), §491.12(d)(1). .360(d)(1), §491.12(d)(1). .3748, ASCs at §416.54, ICF/IIDs at §483.475, HHAs zations" under §485.727, CHC/FQHCs at §491.12:] . The [facility] must do all of mergency preparedness res to all new and existing iding services under unteers, consistent with their and existing at thation of all emergency f knowledge of emergency f knowledge of emergency f knowledge of emergency and existing and existing at	E	037			

Event ID: KQNC11

Facility ID: VA0043

If continuation sheet Page 6 of 78

						O. 0938-03	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	· · · ·	E SURVEY IPLETED	
		495330	B. WING		07/22/2021		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY N CHESAPEAKE, VA 23323	NORTH		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
E 037	Continued From page	e 6	E 03	37			
	(iv) Periodically review						
		ness plan with hospice					
		nonemployee staff), with					
		ced on carrying out the					
	-	y to protect patients and					
	others.						
		ntation of all emergency					
	preparedness training	J. preparedness policies and					
		icantly updated, the hospice					
		on the updated policies and					
	procedures.						
	*[For PRTFs at §441.	184(d)·1 (1) Training					
		must do all of the following:					
		nergency preparedness					
		es to all new and existing					
	staff, individuals prov	•					
		unteers, consistent with their					
	expected roles.	n provide emergeney					
	(ii) After initial training preparedness training						
		f knowledge of emergency					
	procedures.						
	(iv) Maintain docume	ntation of all emergency					
	preparedness training						
		preparedness policies and					
		icantly updated, the PRTF					
	procedures.	on the updated policies and					
	*[For PACE at §460.8	34(d):] (1) The PACE					
	organization must do	· / = · /					
		nergency preparedness					
		res to all new and existing					
		iding on-site services under					
	-	tors, participants, and twith their expected roles.					
	⊨volumeers consisten					1	

Facility ID: VA0043

If continuation sheet Page 7 of 78

					a · · · -	<u>O. 0938-03</u>	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED	
		495330	B. WING		07	07/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY M CHESAPEAKE, VA 23323	NORTH		
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE	
E 037	Continued From page	ə 7	E 03	37			
		cy preparedness training at	200				
	least every 2 years.						
		f knowledge of emergency					
		informing participants of					
		go, and whom to contact in					
	case of an emergenc (iv) Maintain docume						
		preparedness policies and					
		icantly updated, the PACE					
		on the updated policies and					
	procedures.						
		t §483.73(d):] (1) Training cility must do all of the					
	following:						
		nergency preparedness					
		res to all new and existing					
	staff, individuals prov						
	expected role.	lunteers, consistent with their					
		cy preparedness training at					
	least annually.	51 1 5					
	(iii) Maintain docume	ntation of all emergency					
	preparedness training						
	(IV) Demonstrate star procedures.	f knowledge of emergency					
		.68(d):](1) Training. The					
	CORF must do all of						
	(i) Provide initial train						
		s and procedures to all new lividuals providing services					
	-	and volunteers, consistent					
	with their expected ro						
		cy preparedness training at					
	least every 2 years.	atation of the two to to .					
	(iii) Maintain docume	ntation of the training. f knowledge of emergency					
	(iv) Demonstrate star	i knowledge of efficigency					

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	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUUT		INSTRUCTION		NO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	` ´			· · · ·	MPLETED	
		495330	B. WING			07/22/2021		
NAME OF PR	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDIC	CAL CENTER			GEORGE WASHINGTON HIGHWAY NG SAPEAKE, VA 23323	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
E 037	Continued From pag	ge 8	E	037				
		personnel must be oriented						
	and assigned specif							
	the CORF's emerge							
	-	he training program must						
		n the location and use of signals and firefighting						
	equipment.							
		y preparedness policies and						
	procedures are sign	ificantly updated, the CORF						
		g on the updated policies and						
	procedures.							
	*IFor CAHs at 8485	.625(d):] (1) Training program.						
	The CAH must do a							
	(i) Initial training in e	mergency preparedness						
		ures, including prompt						
		uishing of fires, protection,						
		ry, evacuation of patients, sts, fire prevention, and						
		fighting and disaster						
	authorities, to all nev							
	individuals providing	services under arrangement,						
		sistent with their expected						
	roles.	ncy preparedness training at						
	least every 2 years.	icy preparedness training at						
		entation of the training.						
	()	aff knowledge of emergency						
	procedures.							
		y preparedness policies and						
		ificantly updated, the CAH g on the updated policies and						
	procedures.							
		25 020(d):1(1) Training The						
		35.920(d):] (1) Training. The initial training in emergency						
		es and procedures to all new						
	and existing staff, in							

Facility ID: VA0043

If continuation sheet Page 9 of 78

CENTER	MENT OF HEALTH AN S FOR MEDICARE & M DF DEFICIENCIES	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE		FORM	D: 11/18/2021 APPROVED 0. 0938-0391 SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	ì í			· /	LETED
		495330	B. WING			07/3	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	LCENTER			017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 037	with their expected rol documentation of the demonstrate staff kno procedures. Thereaft emergency preparedry years. This REQUIREMENT by: Based on record revie facility staff failed to p preparedness training facility's risk assessme The findings included: During an interview or with the interim admin documentation of ann preparedness training emergency preparedr policies and procedure interim administrator w training and testing in employee's. The risk assessment in 2019. The risk assess for epidemic and infec- ranked epidemic as # (0) occurrences.	Ind volunteers, consistent les, and maintain training. The CMHC must wledge of emergency er, the CMHC must provide ness training at least every 2 is not met as evidenced ew and staff interview, the rovide emergency program based on the ent. n 07/21/21 at 11: 56 A.M. histrator, he was asked for ual emergency and testing program in ness risk assessment es for five current staff. The was not able to provide	E	037			

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						0.0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED	
		495330	B. WING		07/22/2021		
NAME OF P	ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY NORT CHESAPEAKE, VA 23323	IORTH		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 000	Continued From page	e 10	F 000				
F 000	INITIAL COMMENTS		F 000				
F 550 SS=D	survey was conducte Corrections are requi CFR Part 483 Federa requirements. The Li survey/report will follo investigated during th The census in this 12 88 at the time of the s consisted of 56 Resic Resident Rights/Exer CFR(s): 483.10(a)(1) §483.10(a) Resident The resident has a rig self-determination, an access to persons an	ife Safety Code ow. No complaints were he survey. 0 certified bed facility was survey. The survey sample lent reviews cise of Rights (2)(b)(1)(2) Rights. ght to a dignified existence, and communication with and	F 550				
	with respect and dign resident in a manner promotes maintenanc her quality of life, rece individuality. The faci promote the rights of	and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and the resident.					
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source.					

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495330	B. WING			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENB	RIER REGIONAL MEDICA	AL CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From page	e 11	F	550			
	rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, c reprisal from the facilit rights and to be suppo- exercise of his or her subpart. This REQUIREMENT by: Based on observatio and staff interview, th maintain a resident's bedside drainage bag view for 1 of 56 reside survey sample. The findings included Resident #14 was orig 12/11/18 and has new facility. The current di Sclerosis and neurog The quarterly Minimu assessment with an a (ARD) of 3/11/21 cod completing the Brief I (BIMS) and scoring 7	right to exercise his or her f the facility and as a citizen ted States. cility must ensure that the his or her rights without h, discrimination, or reprisal sident has the right to be coercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this is not met as evidenced ns, clinical record review, he facility's staff failed to dignity by ensuring the g fluid was concealed from ents (Resident #14), in the cility'rer been discharged from the iagnoses included; Multiple enic bladder. m Data Set (MDS) assessment reference date					

Facility ID: VA0043

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		D HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/18/2021 M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495330	B. WING			07	/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	L CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	In section "G" (Physic was coded as requirin with bed mobility and person with dressing, and bathing, and supe eating. In section "H" resident was coded at of an indwelling cather The current Physician an order which read; s French/10 milliliters b diagnosis neuromusc bladder. Catheter cha On 7/20/21 at approxi #14 was observed in bag viewable from the contained yellow urine On 7/21/21 at approxi #14 was again observed the hallway was a bed yellow urine with white An interview was com Manager on 7/21/21 at have a fig leaf drainag bag that preserves the hiding the fluid from v Cover) and it would b On 7/22/21 at approxi	were severely impaired. al functioning) the resident tog total care of two people transfers, total care of one toileting, personal hygiene ervision after set-up with (Bladder and Bowel) the t "H0100" as requiring use ter. 's Order summary revealed suprapubic catheter 18 ub to bedside drainage, ular dysfunction of the ange by the urologist. imately 1:45 p.m., Resident bed with a bedside drainage e hallway. The drainage bag e. imately 11:00 a.m., Resident ved in bed. Viewable from dside drainage bag holding ish looking particles.	F	550			
	findings were shared Director of Nursing ar	with the Administrator,					

Facility ID: VA0043

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI TIPI F	CONSTRUCTION		NO. 0938-039	
	CORRECTION	IDENTIFICATION NUMBER:	. ,			MPLETED	
		495330	B. WING		0	7/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	1	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
GREENB	RIER REGIONAL MEDICA	AL CENTER	-	17 GEORGE WASHINGTON HIGHWAY HESAPEAKE, VA 23323	GHWAY NORTH		
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 550	Continued From page	e 13	F 550				
	bag contents should i the hallway.	not have been viewable from					
F 577 SS=D	Right to Survey Resu	lts/Advocate Agency Info))(11)	F 577				
	 §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. 						
	and family members a residents, the results the facility. (ii) Have reports with certifications, and cor respecting the facility years, and any plan of respect to the facility, to review upon reque (iii) Post notice of the areas of the facility th accessible to the pub (iv) The facility shall r information about cor This REQUIREMENT by: Based on information Resident Council Med facility staff failed to in	dily accessible to residents, and legal representatives of of the most recent survey of respect to any surveys, mplaint investigations made during the 3 preceding of correction in effect with available for any individual st; and availability of such reports in at are prominent and lic. not make available identifying mplainants or residents. is not met as evidenced n obtained during the eting, and interviews, the nform residents of the book which listed the					

Facility ID: VA0043

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	S FOR MEDICARE &					O. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		· · ·	e survey Ipleted	
		495330	B. WING		07	7/22/2021	
IAME OF PI	ROVIDER OR SUPPLIER	•	ST	REET ADDRESS, CITY, STATE, ZIP COD	Ē		
GREENBR	RIER REGIONAL MEDIC	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 577	Continued From page	e 14	F 577				
	The findings included	:					
	11:00 AM. Six resident The residents stated location of the survey aware they could see conducted Upon inst results book it was de recent complaint surv in the survey book. T survey book was date the Office of Licensur complaint surveys we following dates: 12/12 These surveys should	n 7/21/21 at approximately, ints attended the meeting. they were not aware of the results book or were not the results of past surveys spection of the survey etermined that the most vey results were not posted he last survey posted in the ed 12/23/2019. According to re and Certification ere conducted on the 2/20, 2/12/21 and 4/15/21. d have been posted in the ents, family members and to view.					
intervi (OSM, reside they w book o Activit	(OSM/Other Staff Me residents in the Resid they were not aware book or the purpose	eted with the Activity Director or mber #2) regarding the dent Council staff stating of the location of the survey of the survey book. The d, "I haven't been working					
E ====	Assistant Director of Corporate Nurse on 7 4:40 PM during the p comments were mad	rector of Nursing, The Nursing (ADON) and the 7/21/21 at approximately re-exit interview. No further e.					
F 578 SS=E		ntnue Trmnt;FormIte Adv Dir	F 578				

Facility ID: VA0043

If continuation sheet Page 15 of 78

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/18/2021 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE	
		495330	B. WING		_	07/:	22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
GREENBF	RIER REGIONAL MEDICA			017 GEORGE WASHINGT CHESAPEAKE, VA 233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 578	§483.10(c)(6) The rigit discontinue treatment to participate in experi- formulate an advance §483.10(c)(8) Nothing construed as the right the provision of medic services deemed medi- inappropriate. §483.10(g)(12) The far requirements specifie subpart I (Advance Di- (i) These requirements inform and provide wr residents concerning medical or surgical tre- resident's option, form (ii) This includes a wri- facility's policies to im and applicable State I (iii) Facilities are perm entities to furnish this legally responsible for requirements of this s (iv) If an adult individu time of admission and information or articula has executed an adva- may give advance dir- individual's resident re- with State Law. (v) The facility is not r provide this informatio or she is able to recei Follow-up procedures	ht to request, refuse, and/or t, to participate in or refuse imental research, and to a directive. If in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or acility must comply with the d in 42 CFR part 489, irectives). Is include provisions to ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. Itten description of the plement advance directives aw. nitted to contract with other information but are still r ensuring that the ection are met. It is incapacitated at the d is unable to receive the whether or not he or she ance directive, the facility ective information to the epresentative in accordance elieved of its obligation to on to the individual once he	F 578				

Facility ID: VA0043

If continuation sheet Page 16 of 78

							FORM): 11/18/2021 1 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495330	B. WING				07/:	22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBF	RIER REGIONAL MEDICA				017 GEORGE WASHINGTON HIGHWAY HESAPEAKE, VA 23323	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 578	appropriate time. This REQUIREMENT by: Based on medical re- and facility document ensure that 10 of 56 r sample were afforded an Advance Directive #52, #257, #258, #25 and #94. The findings included 1. Resident #52 was initially on 8/12/20 and diagnoses to include 1 Mellitus, Hypertension Disorder. Resident #52's most r Set) was a Quarterly r Reference Date) of 6/ (Brief Interview for Me 7 out of a possible 15 moderately cognitively some daily decision r Resident #52's Physic 7/7/21 was reviewed a as follows: Care Plan: Resident #52's Comp	is not met as evidenced cord review, staff interviews review the facility failed to residents in the survey the opportunity to formulate upon admission, Residents' 5, #26, #57, #48, #7, #25 : admitted to the facility d readmitted on 6/29/20 with but not limited to Diabetes n and Major Depressive recent MDS (Minimum Data with an ARD (Assessment '4/21. Resident #52's BIMS ental Status) was coded as a indicating the resident was y impaired but capable of	F	578				

Facility ID: VA0043

If continuation sheet Page 17 of 78

	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 11/18/2021 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495330	B. WING			07	22/2021
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	Continued From page	÷ 17	F	578	3		
	Resident #52's Physic and are documented	cian Orders were reviewed in part, as follows:					
	Start Date: 10/22/19 Order Description: Fi	ull Code					
		onic medical record was as no advance directive					
		M. the ASM (Administrative s asked if he could located for Resident #52.					
	"We don't have any d	SM#1. The ASM#1 stated, ocumentation to support ctive was reviewed with the					
		d "Advance Directives" 06 was reviewed and is as follows:					
		lvance Directives will be nce with state law and					
	Policy Interpretation a	and Implementation:					
	with written information refuse or accept med	he resident will be provided on concerning the right to ical or surgical treatment dvance directive if he or she					
		Imission of a resident, the tor or designee will inquire					

Facility ID: VA0043

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SERVICES					FORM	0: 11/18/2021 APPROVED
R/SUPPLIER/CLIA	. ,				(X3) DATE	
495330	B. WING				07/:	22/2021
		ST	REET ADDRESS, CITY, STATE, ZI	P CODE		
				GHWAY NORTH		
CEDED BY FULL	ID PREFIX TAG	ĸ	(EACH CORRECTIVE A CROSS-REFERENCED T	CTION SHOULD BI		(X5) COMPLETION DATE
the existence of ot the resident e shall be cal record. or she has not e facility staff g advance : debriefing was M #3 and ASM s shared. Prior provided. the facility on but not limited abetes Mellitus, ailure. 6 (Minimum y with an ARD 7/6/21. as a 12 out of a : was cognitively n making. ss Note dated	F 5	578				
	SERVICES RSUPPLIER/CLIA ATION NUMBER: 495330 EFICIENCIES CEDED BY FULL G INFORMATION) Abers and/or his the existence of a of the resident e shall be cal record. a or she has not be facility staff g advance t debriefing was M #3 and ASM is shared. Prior provided. b the facility on but not limited iabetes Mellitus, ailure. S (Minimum by with an ARD 7/6/21. a sa 12 out of a t was cognitively on making. ass Note dated imented in part,	R/SUPPLIER/CLIA (X2) MULT A. BUILDIN A. BUILDIN 495330 B. WING_ 495330 B. WING_ FICIENCIES ID CEDED BY FULL PREFID G INFORMATION) TAG F 5 nbers and/or his the existence of not the resident e shall be cal record. e or she has not ne facility staff g advance t debriefing was M #3 and ASM is shared. Prior provided. o the facility on but not limited iabetes Mellitus, ailure. S (Minimum vy with an ARD 7/6/21. as a 12 out of a t was cognitively n making. ess Note dated	R/SUPPLIER/CLIA (X2) MULTIPLE ABUILDING 495330 B. WING 495330 B. WING 10 C 2 ST 11 C 2 ST 11 ST 12 ST 13 ST 14 ST 15 ST 16 ST 17 ST 18 ST 17 ST	RISUPPLIER/CLIA ATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 495330 B. WING 495330 B. WING STREET ADDRESS, CITY, STATE, ZI 1017 GEORGE WASHINGTON HIG CHESAPEAKE, VA 23323 FFICIENCIES CEDED BY FULL G INFORMATION) PREFIX TAG PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE nbers and/or his the existence of PREFIX TAG not the resident e shall be ccal record. F 578 or she has not the facility staff g advance F 378 t debriefing was M #3 and ASM is shared. Prior provided. Not the facility on but not limited labetes Mellitus, ailure. S (Minimum ty with an ARD 7/6/21. as a 12 out of a t was cognitively un making. A M bit should be be continued bit was cognitively un making.	RISUPPLIERICLIA (X2) MULTIPLE CONSTRUCTION ATION NUMBER: A BUILDING 495330 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 1017 GEORGE WASHINGTON HIGHWAY NORTH CHECKLES PREFIX TAG PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIA D PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY D PROVIDER'S PLAN OF CORRECTION CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY DEFICIE	RNSUPPLIERICLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE ABUILDING

Event ID: KQNC11

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY LETED
		495330	B. WING			07/	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA	AL CENTER			017 GEORGE WASHINGTON HIGHWAY NORTH HESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 578	Resident #257's Com revised 7/14/21 was r in part, as follows: Full Code Resident #257's Phys and are documented Start Date: 6/30/21 Order Description: Fu Resident #257's elect reviewed and there w document located. On 7/21/21 at 2:15 P. he could located the a Resident #257. On 7/22/21 at 9:53 A. conducted with the AS "We don't have any di that an Advance Direct resident upon admiss The facility policy title revised December 20 documented in part, a Policy Statement: Ad respected in accordar facility policy. Policy Interpretation a 1. Upon admission, th with written informatic	 apprehensive Care Plan last reviewed and is documented sician Orders were reviewed in part, as follows: aull Code tronic medical record was ras no advance directive M. the ASM#1 was asked if advance directive for M. an interview was SM#1. The ASM#1 stated, ocumentation to support ctive was reviewed with the ion. d "Advance Directives" 06 was reviewed and is as follows: Ivance Directives will be nce with state law and 	F 5	78			

Event ID: KQNC11

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DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MEL						FORM	0: 11/18/2021 1 APPROVED 0. 0938-0391
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE	
	495330	B. WING _				07/:	22/2021
NAME OF PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		_	
GREENBRIER REGIONAL MEDICAL C	ENTER			017 GEORGE WASHINGTON HIGHWAY N HESAPEAKE, VA 23323	IORTH		
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
 F 578 Continued From page 20 and to formulate an advar chooses to do so. 6. Prior to or upon admiss Social Services Director of of the resident, his/her far or her legal representative any written advance director of the resident advance displayed prominently in the sexecuted an advance displayed prominently in the 8. If the resident indicate established advance directores. On 7/22/21 at 4:25 P.M. a held with the ASM #1, AS #4 were the above inform to exit no further information advances to Spinal Stenosis, Hyper Disorder. Resident #258's Admission progress due to resident I Resident #258's BIMS was possible 15 indicating the intact and capable of daily Resident #258's Physicia 7/20/21 was reviewed and as follows: 	sion of a resident, the or designee will inquire mily members and/or his e, about the existence of ctives. ther or not the resident e directive shall be the medical record. s that he or she has not ctives, the facility staff tablishing advance a pre-exit debriefing was SM #, ASM #3 and ASM hation was shared. Prior ion was provided. Imitted to the facility on o include but not limited tension and Anxiety on 5-day MDS is in being a new admission. as coded as a 14 out of a e resident was cognitively y decision making. In Progress Note dated	F	578				

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS		DMB NO. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED
495330 B. WING		07/22/2021
NAME OF PROVIDER OR SUPPLIER STREET	ET ADDRESS, CITY, STATE, ZIP CODE	
GREENBRIER REGIONAL MEDICAL CENTER	GEORGE WASHINGTON HIGHWAY NORTH SAPEAKE, VA 23323	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
F 578 Continued From page 21 History: Code Status-Full Code F 578 Resident #258's Baseline Care Plan last revised 7/20/21 was reviewed and is documented in part, as follows: Full Code Full Code Resident #258's Physician Orders were reviewed and are documented in part, as follows: Start Date: 7/12/21 Order Description: Full Code Resident #258's electronic medical record was reviewed and there was no advance directive document located. On 7/21/21 at 2:15 P.M. the ASM#1 was asked if he could located the advance directive for Resident #258. On 7/22/21 at 9:53 A.M. an interview was conducted with the ASM#1. The ASM#1 stated, "We don't have any documentation to support that an Advance Directive was reviewed with the resident upon admission. The facility policy titled "Advance Directives" revised December 2006 was reviewed and is documented in part, as follows: Policy Statement: Advance Directives will be respected in accordance with state law and facility policy. Policy Interpretation and Implementation:		

Facility ID: VA0043

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DEPARTMENT OF HEALTH AND H CENTERS FOR MEDICARE & MED						FORM	D: 11/18/2021 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1)	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	
	495330	B. WING				07/	22/2021
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP	CODE	-	
GREENBRIER REGIONAL MEDICAL CI	ENTER			1017 GEORGE WASHINGTON HIG CHESAPEAKE, VA 23323	HWAY NORTH		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEI	CTION SHOULD B		(X5) COMPLETION DATE
 F 578 Continued From page 22 Upon admission, the rewith written information correfuse or accept medical dand to formulate an advarchooses to do so. Prior to or upon admission, the resident, his/her faror her legal representative any written advance direct Information about whe has executed an advance displayed prominently in t If the resident indicates established advance direct will offer assistance in est directives. On 7/22/21 at 4:25 P.M. a held with the ASM #1, AS #4 were the above inform to exit no further information advance to exit no further information advance directives. Resident #255's Admission progress due to resident to resident the cognitively impaired but cadecision making. 	oncerning the right to or surgical treatment nee directive if he or she sion of a resident, the or designee will inquire nily members and/or his e, about the existence of tives. ther or not the resident e directive shall be he medical record. Is that he or she has not ctives, the facility staff ablishing advance a pre-exit debriefing was M #, ASM #3 and ASM ation was shared. Prior on was provided. mitted to the facility on nclude but not limited to d Pressure Ulcers. on 5-day MDS is in being a new admission. as coded as a 5 out of a resident was severely apable of some daily	F	578				

Facility ID: VA0043

If continuation sheet Page 23 of 78

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495330	B. WING			07/	/22/2021
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	AL CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 578	Continued From page 7/12/21 was reviewed as follows: History: Code Status-Full Cod Resident #255's Base 7/12/21 was reviewed as follows: Full Code Resident #255's Phys and are documented in Start Date: 7/9/21 Order Description: Fu Resident #255's elect reviewed and there w document located. On 7/21/21 at 2:15 P. he could located the a Resident #255. On 7/22/21 at 9:53 A. conducted with the AS "We don't have any do that an Advance Direct resident upon admiss	e 23 d and is documented in part, le eline Care Plan last revised d and is documented in part, sician Orders were reviewed in part, as follows: ull Code tronic medical record was ras no advance directive M. the ASM#1 was asked if advance directive for M. an interview was SM#1. The ASM#1 stated, ocumentation to support ctive was reviewed with the ion.		578			
		d "Advance Directives" 06 was reviewed and is as follows:					
		lvance Directives will be nce with state law and					

Facility ID: VA0043

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495330	B. WING			07/	22/2021	
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDICA	AL CENTER			017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 578	Continued From page	24	F	578				
	Policy Interpretation a	and Implementation:						
	with written informatic refuse or accept med	he resident will be provided on concerning the right to ical or surgical treatment dvance directive if he or she						
	Social Services Direct of the resident, his/he	Imission of a resident, the tor or designee will inquire er family members and/or his tative, about the existence of directives.						
	has executed an adva	whether or not the resident ance directive shall be / in the medical record.						
	established advance	cates that he or she has not directives, the facility staff n establishing advance						
	held with the ASM #1	M. a pre-exit debriefing was , ASM #, ASM #3 and ASM formation was shared. Prior mation was provided.						
	9/14/16 and readmitted diagnoses that include high blood pressure, I and schizophrenia. Re MDS (Minimum data s quarterly assessment reference date) of 3/1	admitted to the facility on ed on 7/20/20 with ed but were not limited to high cholesterol, dementia, esident #26's most recent set) assessment was a t with an ARD (assessment 5/21. Resident #26 was rely impaired in cognitive						

Facility ID: VA0043

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DEPARTMENT OF HEALTH AND					FORM	D: 11/18/2021 APPROVED D: 0938-0391	
CENTERS FOR MEDICARE & M STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495330	B. WING _			07/	22/2021	
NAME OF PROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-		
GREENBRIER REGIONAL MEDICAL	CENTER			17 GEORGE WASHINGTON HIGHWAY NORTH HESAPEAKE, VA 23323			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
On 7/21/21 at 10:12 a.t conducted with Reside her husband. Her husb admission, staff had on Resuscitate) or Full Co stated that the discussi prolonging measures s intravenous fluids and a needed; did not occur. Review of Resident #24 a Durable Do Not Resu the physician and date hospital. The following "The patient is incapab decision about providin withdrawing a specific course of medical treat unable to understand th probable consequence decision, or to make a risks and benefits of all decision, the patient ha advanced directive whi prolonging measures b This document was sig Party.	of possible 15 on the or Mental Status) exam. m., an interview was nt #26's responsible party, and had stated that upon by went over DNR (Do Not de Status. Her husband fon regarding additional life uch as enteral feeding, a ventilator/tracheotomy if 6's clinical record revealed uscitate Order signed by d for 2008 from the was documented: le of making an informed ag, withholding, or medical treatment or ment because he/she is he nature, extent, or s of the proposed medical rational evaluation of the ternative to the le of making an informed as executed a written ch directs that life e withheld or withdrawn." ined by the Responsible	F 5	578				

Facility ID: VA0043

If continuation sheet Page 26 of 78

	-	D HUMAN SERVICES MEDICAID SERVICES				FOF	ED: 11/18/2021 RM APPROVED O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		495330	B. WING			0	7/22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	.	
GREENBF	RIER REGIONAL MEDICA	L CENTER			1017 GEORGE WASHINGTON HIGHWAY NORT CHESAPEAKE, VA 23323	н	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	IX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 578	 Nursing). ASM #1 sta advanced directive fo stated that if residents directive upon admiss will file that into the re- they will offer resident directive, but if the resident directive, but if the resident directives, but if the resident directives was discuss admission. On 7/22/21 at approxi (Administrative Staff M Administrator; ASM # Nursing), ASM #3, the of Nursing) and the C made aware of the ab- information was prese 6) Resident #57 was 10/17/20 with diagnos not limited to Anemia, insufficiency requiring pressure. Resident #57 (Minimum Data Set) a assessment with an A date) of 4/11/21. Resi- being intact in cogniti- possible 15 on the BII Mental Status) exam. On 7/21/21 at 2:00 p. conducted with Resid not determine if she w 	ated that they didn't have the r Resident #26. ASM #1 s have an advanced sion from the hospital, they scord. ASM #1 stated that is to formulate an advanced sident refuses, they do not a stated that they didn't on to support that advanced sed with each resident upon imately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director orporate Nurse #1 were bove concerns. No further ented prior to exit. admitted to the facility on ses that included but were atrial fibrillation, renal dialysis, and high blood 57's most recent MDS assessment was a quarterly ARD (assessment reference dent #57 was coded as ve function scoring 15 out of MS (Brief Interview for m., an interview was ent #57. Resident #57 could vas offered to formulate an bon admission. Resident #57	F	578			

Facility ID: VA0043

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495330	B. WING			07/	22/2021	
NAME OF P	ROVIDER OR SUPPLIER			Ś	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDICA	AL CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 578	Continued From page directive was.	27	F	578	3			
	a Durable Do Not Res	57's clinical record revealed suscitate Order signed by ident on 7/8/20 from the g was documented:						
	decision about provid withdrawing a specific course of medical trea	c medical treatment or atment" The next section esident #57 had executed an						
	found in her clinical re	nced directive could not be ecord or any evidence that assist Resident #57 with ced directive.						
	Nursing). ASM #1 sta advanced directive fo stated that if residents directive upon admiss will file that into the re- they will offer resident directive, but if the resident directive, but if the resident directive, but if the resident directive, but if the resident attempt again. ASM #	(Administrative Staff / #2, the DON (Director of ated that they didn't have the r Resident #57. ASM #1						
	(Administrative Staff M Administrator; ASM # Nursing), ASM #3, the	imately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director corporate Nurse #1 were						

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391	
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495330	B. WING			07/	22/2021	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDICA				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 578	7) Resident #48 was 1/13/20 and readmitte diagnoses that include heart failure, high bloc mellitus, high choleste and dementia. Reside (minimum data set) a assessment with an A Reference Date) of 4/ coded as being sever function scoring 00 ou Interview for Mental S Review of Resident # a Durable Do Not Res	admitted to the facility on ed on 1/24/21 with ed but were not limited to od pressure, diabetes erol, Alzheimer's disease, ent #48's most recent MDS ssessment was a quarterly ARD (Assessment /2/21. Resident #48 was rely impaired in cognitive ut of 15 on the BIMS (Brief	F	578				
	"The patient is incapa decision about provid withdrawing a specific course of medical trea unable to understand probable consequence decision, or to make a risks and benefits of a decisionWhile capa decision, the patient h advanced directive will prolonging measures This document was si PartyThe patient ha	c medical treatment or atment because he/she is the nature, extent, or ses of the proposed medical a rational evaluation of the alternative to the ble of making an informed has executed a written hich directs that life be withheld or withdrawn." igned by the Responsible is not executed a written ving will or durable power of						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495330	B. WING			07/	22/2021	
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDICA	L CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 578	and assisted Residen advanced directive. On 7/22/21 at 9:50 a.1 conducted with ASM (Member) #1 and ASM Nursing). ASM #1 sta advanced directive fo stated that if residents directive upon admiss will file that into the re- they will offer resident directive, but if the res- attempt again. ASM # have the documentati directives was discuss admission. On 7/22/21 at approxi (Administrator; ASM # Nursing), ASM #3, the of Nursing) and the C	t #48 with formulating an m., an interview was (Administrative Staff 1 #2, the DON (Director of ated that they didn't have the r Resident #48. ASM #1 s have an advanced sident refuses, they do not 1 stated that they didn't on to support that advanced sident refuses, they do not 1 stated that they didn't on to support that advanced sed with each resident upon mately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director orporate Nurse #1 were pove concerns. No further	F	578	В			
	1/18/19 and readmitted diagnoses that include End Stage Renal Dise Disorder.	dmitted to the facility on ed on 11/25/20 with ed but were not limited to ease and Major Depressive cent MDS (Minimum Data						

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495330	B. WING			07/	22/2021	
NAME OF PI	ROVIDER OR SUPPLIER		•	\$	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDICA	L CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 578	date) of 03/03/21. Resiscoring 5 out of possi Interview for Mental S Resident #7's cognitive making were severely A review of the clinical revealed there were re- clinical record for resis 9. Resident #32 was a 06/04/18 and readmit diagnoses included; F Unspecified Dementia Disturbance. ** Resident #32's most Data Set Assessment assessment with an A date) of 03/10/21. Resistent #32's cognit making were moderat A review for Mental S Resident #32's cognit making were moderat A review of the clinical revealed there were re clinical record for resis 10. Resident #94 was 05/09/19 and readmit diagnoses included; L without Behavioral Dis Hypertension.	a quarterly revision RD (assessment reference sident #7 was coded as ble 15 on the BIMS (Brief tatus exam). This indicated re abilities for daily decision r impaired. I records on 7/21/21 to advance directives in the dent #7. admitted to the facility on ted on 07/08/20. The current Parkinson's disease and a without Behavioral at recent MDS (Minimum) was an annual RD (assessment reference sident #32 was coded as sible 15 on the BIMS (Brief tatus exam). This indicated ive abilities for daily decision ely impaired. I records on 7/21/21 to advance directives in the dent #32. admitted to the facility on ted on 05/23/19. The current Unspecified Dementia sturbance and Essential	F	578				
	Resident #94's most r	ecent MDS (Minimum Data						

Facility ID: VA0043

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TATES			0(0)				
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		· · ·	E SURVEY IPLETED	
		495330	B. WING		0	7/22/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E		
GREENBF	RIER REGIONAL MEDIC	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY CHESAPEAKE, VA 23323			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 578	Set Assessment) an a ARD (assessment rei Resident #94 was co possible 15 on the BI Mental Status exam). #94's cognitive abilitie were severely impaire A review of Resident 7/21/21 revealed no A On 07/21/21 at appro- interview was conduct Advance Directives of and Resident #94. Sh directives are on file. ¹ On 07/22/21 at appro- interview was conduct and DON (Director of Advance Directives.	annual assessment with an ference date) of 05/23/21. ded as scoring 3 out of MS (Brief Interview for . This indicated Resident es for daily decision making ed. #94's clinical record on Advanced Directive. eximately 12:52 PM an cted with OSM #1 concerning on Resident #7, Resident #25 he stated, "No advance " eximately 9:45 AM an cted with the Administrator f Nursing) concerning The Administrator stated, int supporting that the	F 578	3			
F 582 SS=D	meeting was conduct Director of Nursing, T Nursing and with the concerning the above documents were offe Medicaid/Medicare C	coverage/Liability Notice /)(18)(i)-(v)	F 582	2			

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						FORM): 11/18/2021 1 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495330	B. WING		-	07/2	22/2021
NAME OF PI	ROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA			1017 GEORGE WASHINGTO CHESAPEAKE, VA 2332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 582	facility and when the n Medicaid of- (A) The items and ser nursing facility service for which the resident (B) Those other items facility offers and for w charged, and the amo services; and (ii) Inform each Medic changes are made to specified in §483.10(g) section. §483.10(g)(18) The far resident before, or at periodically during the available in the facility services, including an covered under Medica facility's per diem rate (i) Where changes in and services covered Medicaid State plan, the notice to residents of reasonably possible. (ii) Where changes are items and services the facility must inform the 60 days prior to imple (iii) If a resident dies of transferred and does facility must refund to representative, or esta deposit or charges all per diem rate, for the	resident becomes eligible for rvices that are included in es under the State plan and may not be charged; and services that the which the resident may be bount of charges for those raid-eligible resident when the items and services g)(17)(i)(A) and (B) of this acility must inform each the time of admission, and e resident's stay, of services y and of charges for those by charges for services not are/ Medicaid or by the the facility must provide the change as soon as is re made to charges for other at the facility offers, the e resident in writing at least mentation of the change. or is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any ready paid, less the facility's days the resident actually r retained a bed in the	F 582				

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CENTER STATEMENT (S FOR MEDICARE & I	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	FORM OMB NC (X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMP	LETED
		495330	B. WING			07/	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA	L CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 582	resident representative the resident within 30 date of discharge from (v) The terms of an action behalf of an individual facility must not confli- these regulations. This REQUIREMENT by: Based on clinical rec- and facility documenta- to ensure Medicare B- accordance with appli- were issued to 2 of 3 Resident 55) in the su The findings included 1. The facility staff fa Beneficiary Notice (Al- who was discharged fa Medicare days remain originally admitted to 03/17/21. Diagnosis fa but not limited to Con- Resident #34's Minim OBRA quarterly asses Reference Date (ARD Resident #34 a 10 ou on the Brief Interview indicated moderate co Review of the SNF Be Review provided by th noted that Resident # been issued the SNF	irements. efund to the resident or re any and all refunds due days from the resident's in the facility. dmission contract by or on I seeking admission to the ct with the requirements of is not met as evidenced ord review, staff interview ation, the facility staff failed eneficiary Notices in icable Federal regulations, residents (Resident #34 and urvey sample. illed to issue an Advanced BN) letter to Resident #34 from skilled services with hing. Resident #34 was the nursing facility on for Resident #34 included gestive Heart Failure (CHF). um Data Set (MDS) an assment with an Assessment b) date of 03/22/21 coded t of a possible score of 15 for Mental Status (BIMS), ognitive impairment. eneficiary Notification he facility to surveyor, was 34 was not listed for having	F	582			

Facility ID: VA0043

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495330	B. WING			07/	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA	L CENTER			017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 582	resident had received Medicare Provider No copy of the SNF ABN Resident #34 started 03/17/21 and the last was 04/02/20. Reside from Medicare Part A were not exhausted. 32 days of his Medica days remaining. Resi issued a SNF ABN an #34 was only issued a An interview was cond (SW) on 07/21/21 at a When asked if Reside ABN, she replied, "No to be issued if the res with skilled services a wasn't' going to pay fo 2. The facility staff fail Beneficiary Notice (Al who was discharged 1 Medicare days remain admitted to the nursin Diagnosis for Resider limited to muscle wea Minimum Data Set (M Assessment with an A (ARD) date of 04/09/2 out of a possible score Interview for Mental S moderate cognitive im Review of the SNF Be Review provided by th	a NOMNC (Notice of on-Coverage), however; no was provided. a Medicare Part A stay on covered day of this stay ent #34 was discharged services when benefit days Resident #34 had only used are Part A services with 68 ident #34 should have been to an NOMNC. Resident an NOMNC. Resident an NOMNC. ducted with Social Worker approximately 11:10 a.m. ent #34 was issued and b, I thought an ABN was only ident wanted to continue and knowing that Medicaid bor the rest of their stay." ed to issue an Advanced BN) letter to Resident #55 from skilled services with hing. Resident #55 was g facility on 01/08/21. ht #55 included but not kness. Resident #55's IDS) an OBRA Quarterly Assessment Reference Date 21 coded Resident #55 a 09 e of 15 on the Brief status (BIMS), indicated hpairment.	F	582			

Facility ID: VA0043

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AN SERVICES				FORM): 11/18/2021 1 APPROVED). 0938-0391	
VIDER/SUPPLIER/CLIA	· <i>′</i>			(X3) DATE SURVEY COMPLETED		
495330	B. WING _		_	07/22/2021		
		STREET ADDRESS, CITY, S	TATE, ZIP CODE			
ER						
		CHESAPEAKE, VA 233	23			
PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
Notice.) The NC (Notice of rage), however; no wided. are Part A stay on d day of this stay was discharged when benefit days t #55 only used 17 ervices with 83 days uld have been DMNC. Resident NC. with Social Worker hately 11:10 a.m. vas issued and ght an ABN was only inted to continue ving that Medicaid st of their stay." or of Nursing DON) efing on 07/21/21 at facility did not n about the findings. cy on NOMNC, irrements)-(iii) harge- ments- ch resident to		82				
	ID SERVICES VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	JD SERVICES VIDER/SUPPLIER/CLIA (X2) MULTI TIFICATION NUMBER: A. BUILDIN 495330 B. WING	ID SERVICES VIDER/SUPPLIER/CLIA TIFICATION NUMBER: 495330 B. WING 495330 B. WING ER DF DEFICIENCIES ID PRECEDED BY FULL PREFIX CROSS-REFERE COUNC (Notice of age), however; no vided States and days tit #55 only used 17 ervices with	ID SERVICES VIDERSUPPLER/CLA TIFICATION NUMBER: 495330 B WING 495330 B WING IR STREET ADDRESS, CITY, STATE, ZIP CODE 107 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323 DF DEFICIENCIES IP DEFICIENCIES IP REPIX CROSS-REFERENCE TO THE APPROPRIA DEFICIENCIES IP REPIX TAG PREFIX CROSS-REFERENCE TO THE APPROPRIA DEFICIENCY) R Vided. are Part A stay on d day of this stay was discharged was discharged when benefit days tt #55 only used 17 ervices with 83 days uld have been MNC. with Social Worker tately 11:10 a.m. vas issued and pht an ABN was only nied to continue ring that Medicaid st of their stay." or ONISING DON) ering on 07/21/21 at facility d	ID SERVICES ONE NO VIDEREVICES ONE NO VIDEREVIENCLA (22) MULTIPLE CONSTRUCTION A BUILDING (23) DATE 495330 B. WING 101 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323 5F DEFICIENCES PRECEDED BY FULL PRECED TO THE APPROPRIATE DEFICIENCES CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 582 solid day of this stay was discharged was discharged was discharged was sissued and ht an ABN was only inted to continue ing that Medicaid sto filterion for filting no 07/21/21 at facility did not n about the findings. cy on NOMNC, irements (cy on NOMNC, irements F 622	

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	-	D HUMAN SERVICES MEDICAID SERVICES			FOR	ED: 11/18/2021 MAPPROVED O. 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\ <i>` `</i>	E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		495330	B. WING		07	/22/2021
NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CREENBRIE	R REGIONAL MEDICA			1017 GEORGE WASHINGTON HIGHWAY	NORTH	
GREENDRIE				CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
d (,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	A) The transfer or dis esident's welfare and annot be met in the f B) The transfer or dis recause the resident's ufficiently so the resident's ervices provided by t C) The safety of indivi- endangered due to the tatus of the resident; D) The health of indiv- therwise be endange E) The resident has f ppropriate notice, to inder Medicare or Medicaid esident Medicare or Medicaid esident refuses to pa esident who becomes dimission to a facility, esident only allowable or F) The facility ceases ii) The facility may no esident while the app (431.230 of this chap exercises his or her right ischarge notice from 31.220(a)(3) of this of the facility may no esident who her right ischarge or transfer or or safety of the reside acility. The facility may	t from the facility unless- icharge is necessary for the the resident's needs acility; icharge is appropriate is health has improved dent no longer needs the he facility; riduals in the facility is e clinical or behavioral viduals in the facility would ered; ailed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. If the resident does not paperwork for third party hird party, including , denies the claim and the y for his or her stay. For a s eligible for Medicaid after , the facility may charge a e charges under Medicaid; a to operate. t transfer or discharge the eal is pending, pursuant to oter, when a resident ght to appeal a transfer or the facility pursuant to § schapter, unless the failure to would endanger the health nt or other individuals in the ust document the danger or discharge would pose.	F 623			

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			0(0)			0.00 -	NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		NSTRUCTION	· · · ·	ATE SURVEY OMPLETED
		495330	B. WING _				07/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP COD	E	
GREENBF	RIER REGIONAL MEDIC	AL CENTER			GEORGE WASHINGTON HIGHWAY SAPEAKE, VA 23323	(NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 622	Continued From page	e 37	F	522			
		sfers or discharges a					
		f the circumstances specified					
		i)(A) through (F) of this					
	section, the facility m	ust ensure that the transfer					
	-	nented in the resident's					
		ppropriate information is					
		receiving health care					
	institution or provider	the resident's medical record					
	must include:						
	(A) The basis for the	transfer per paragraph (c)(1)					
	(i) of this section.						
		agraph (c)(1)(i)(A) of this					
		esident need(s) that cannot					
	-	pts to meet the resident ce available at the receiving					
	facility to meet the ne	•					
		on required by paragraph (c)					
	(2)(i) of this section n						
		ysician when transfer or					
	•	ry under paragraph (c) (1)					
	(A) or (B) of this sect						
		transfer or discharge is					
	this section.	agraph (c)(1)(i)(C) or (D) of					
		ded to the receiving provider					
	must include a minim						
	(A) Contact informati	on of the practitioner					
	responsible for the ca						
		ntative information including					
	contact information (C) Advance Directive	einformation					
		tions or precautions for					
	ongoing care, as app	-					
	(E) Comprehensive of						
	(F) All other necessa	ary information, including a					
		discharge summary,					
	consistent with 8/83	21(c)(2) as applicable, and					

Facility ID: VA0043

If continuation sheet Page 38 of 78

CENTER STATEMENT (AND PLAN OF NAME OF PI	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495330	, í	NG	CONSTRUCTION	FORM OMB NC (X3) DATE COMP	D: 11/18/2021 MAPPROVED D. 0938-0391 SURVEY LETED 22/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	a safe and effective tr This REQUIREMENT by: Based on staff intervi and clinical record rev facility staff failed to e documentation includ physician/RP (respon information were sent Resident #48 upon tra 1/19/21. The findings included Resident #48 was adu 1/13/20 and readmitte diagnoses that include heart failure, high bloc mellitus, high choleste and dementia. Reside (minimum data set) at assessment with an A Reference Date) of 4/ coded as being sever function scoring 00 ou Interview for Mental S Review of Resident # that she was sent out The following nursing part: "During nursing resident was sweating temp (temperature) at was noted to be 166/ Eyes fixed and dilated Resident started to di activity. Oxygen appli	tion, as applicable, to ensure ransition of care. is not met as evidenced iew, facility document review view, it was determined that ensure all the required ing care plan goals and sible party) contact t with one of 56 residents; ansfer to the hospital on : mitted to the facility on ed on 1/24/21 with ed but were not limited to od pressure, diabetes erol, Alzheimer's disease, ent #48's most recent MDS ssessment was a quarterly ARD (Assessment /2/21. Resident #48 was rely impaired in cognitive ut of 15 on the BIMS (Brief Status Exam). 48's clinical record revealed to the hospital on 1/19/21. note was documented in rounds, this writer noted that g profusely. No elevation in t this time. Blood pressure 144, BS (Blood Sugar) 188. d, non reactive to light. splay some seizure like	F	622			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		495330	B. WING _			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
GREENB	RIER REGIONAL MEDICA				117 GEORGE WASHINGTON HIGHWAY NORTH HESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 622	continued convulsions transferred to (Name (Evaluation)." There was no evidence the SBAR (Situation, and recommendation following documentati #48 upon transfer to to (A) Contact information responsible for the ca (B) Resident represent contact information (C) Comprehensive co On 7/21/21 at 10:04 at interview was attempt responsible party. Sho an interview. On 7/22/21 at 1:51 p. conducted with LPN (#2. Resident #48's cu what was sent with ea at the time of an acute stated that the facesh plan goals, and the be with the resident. Whe would be documented documents sent with the state of an acute stated that the facesh plan goals, and the be with the resident. Whe would be documented documents sent with the state of an acute state of acute state	e some facial distortion and s. 911 called and resident of hospital) for further eval. ce in the clinical record or on background, assessment) form dated 1/19/21 that the ion was sent with Resident the hospital: on of the practitioner are of the resident. ntative information including are plan goals a.m. and 12:04 p.m., an ted with Resident #48's e could not be reached for m., an interview was (Licensed Practical Nurse)) irrent nurse. When asked ach resident to the hospital e care transfer, LPN #2 ieet, medication list, care ed hold policy would be sent en asked if information sent d, LPN #2 stated that all the resident should be sing note. When asked how se documents were sent if	F 6	22			

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	-	D HUMAN SERVICES				FORM): 11/18/2021 1 APPROVED
STATEMENT C	FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495330	B. WING		_	07/2	22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
GREENBR	IER REGIONAL MEDICA	L CENTER		017 GEORGE WASHINGT CHESAPEAKE, VA 233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622 F 623 SS=D	sent Resident #48 out could not be reached On 7/22/21 at approxi (Administrative Staff M Administrator; ASM #3, the of Nursing), ASM #3, the of Nursing) and the Co- made aware of the ab- information was prese Facility policy titled, "T notice" did not addres further information wa Notice Requirements CFR(s): 483.15(c)(3)- §483.15(c)(3) Notice B Before a facility transf resident, the facility m (i) Notify the resident a representative(s) of the the reasons for the mo- language and manner facility must send a co- representative of the C Long-Term Care Omb (ii) Record the reason discharge in the resid- accordance with parag- and (iii) Include in the notice paragraph (c)(5) of thi §483.15(c)(4) Timing (i) Except as specified	 p.m., the nurse who had t to the hospital on 1/19/21 for an interview. imately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director orporate Nurse #1 were bove concerns. No further ented prior to exit. Transfer or Discharge as the above concerns. No as presented prior to exit. Before Transfer/Discharge (6)(8) before transfer. fers or discharges a nust- and the resident's ne transfer or discharge and ove in writing and in a r they understand. The poy of the notice to a Office of the State pudsman. as for the transfer or ent's medical record in graph (c)(2) of this section; ce the items described in is section. of the notice. d in paragraphs (c)(4)(ii) and 	F 622				
	(i) Except as specified						

Event ID: KQNC11

Facility ID: VA0043

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		MEDICAID SERVICES				0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE S COMPL		
		495330	B. WING		07/2	2/2021	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	θE		
GREENBR	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWA CHESAPEAKE, VA 23323	AY NORTH		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 623	Continued From page	e 41	F 62	23			
		nder this section must be					
	•	t least 30 days before the					
	resident is transferred	-					
	(ii) Notice must be ma	ade as soon as practicable					
	before transfer or disc	5					
	•	viduals in the facility would					
	-	r paragraph (c)(1)(i)(C) of					
	this section; (B) The health of indiv	viduals in the facility would					
		er paragraph (c)(1)(i)(D) of					
	this section;	······································					
	•	alth improves sufficiently to					
		ate transfer or discharge,					
		1)(i)(B) of this section;					
	(D) An immediate trai	-					
		ent's urgent medical needs, 1)(i)(A) of this section; or					
		t resided in the facility for 30					
	days.						
	§483.15(c)(5) Conten	its of the notice. The written					
	notice specified in pa	ragraph (c)(3) of this section					
	must include the follo						
	(i) The reason for tra						
	(iii) The effective date (iii) The location to wh	of transfer or discharge;					
	transferred or dischar						
		e resident's appeal rights,					
		ddress (mailing and email),					
	and telephone number	-					
		ts; and information on how					
	to obtain an appeal for						
	completing the form a hearing request;	and submitting the appeal					
		ss (mailing and email) and					
		the Office of the State					
	Long-Term Care Omb						
	(vi) For nursing facility						

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/18/2021 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		_	(X3) DATE	0. 0938-0391 SURVEY LETED
		495330	B. WING			07/:	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	L CENTER		1017 GEORGE WASHING CHESAPEAKE, VA 23			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	and developmental di disabilities, the mailine telephone number of the protection and add developmental disabil C of the Developmental and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facilit disorder or related dis email address and tel agency responsible for advocacy of individua established under the for Mentally III Individua §483.15(c)(6) Change If the information in the effecting the transfer must update the recip as practicable once the becomes available. §483.15(c)(8) Notice i In the case of facility of the administrator of the written notification priot to the State Survey Ag State Long-Term Care the facility, and the re well as the plan for the relocation of the resid 483.70(I). This REQUIREMENT by: Based on staff intervi- review, and clinical re determined that facilit	sabilities or related g and email address and the agency responsible for vocacy of individuals with lities established under Part tal Disabilities Assistance of 2000 (Pub. L. 106-402, 15001 et seq.); and y residents with a mental sabilities, the mailing and ephone number of the or the protection and als with a mental disorder e Protection and Advocacy uals Act. es to the notice. the notice changes prior to or discharge, the facility bients of the notice as soon the updated information in advance of facility closure closure, the individual who is the facility must provide or to the impending closure gency, the Office of the e Ombudsman, residents of sident representatives, as e transfer and adequate lents, as required at §	F 62	23			

Facility ID: VA0043

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION	(X3) DATE	
		495330	B. WING			07/	22/2021
NAME OF PR	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	L CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 623	residents; Resident #4 The findings included: 1. Resident #48 was a 1/13/20 and readmitted diagnoses that include heart failure, high bloc mellitus, high choleste and dementia. Reside (minimum data set) as assessment with an A Reference Date) of 4/ coded as being sever function scoring 00 ou Interview for Mental S Review of Resident #4 that she was sent out The following nursing part: "During nursing temp (temperature) at was noted to be 166/ Eyes fixed and dilated Resident started to dia activity. Oxygen applie minute) via nasal cam resident noted to have continued convulsions transferred to (Name (Evaluation)."	I for two of 56 sampled 48 and #52. admitted to the facility on ed on 1/24/21 with ed but were not limited to od pressure, diabetes erol, Alzheimer's disease, ent #48's most recent MDS sesessment was a quarterly .RD (Assessment 2/21. Resident #48 was ely impaired in cognitive it of 15 on the BIMS (Brief itatus Exam). 48's clinical record revealed to the hospital on 1/19/21. note was documented in rounds, this writer noted that g profusely. No elevation in it this time. Blood pressure 144, BS (Blood Sugar) 188. d, non reactive to light. splay some seizure like	F	623			
		provide evidence that the					

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE	
		495330	B. WING _			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER		•	ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
GREENB	RIER REGIONAL MEDICA	L CENTER			17 GEORGE WASHINGTON HIGHWAY NORTH HESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 623	notified of this acute t On 7/22/21 at 11:00 a conducted with OSM the social services as have a social worker. for notifying the long t facility discharges; OS computer system she says "Discharges" an every month to the lon OSM #1 then stated t generated report was were transferred to th that she was not awa asked if she does a c all transfers are being LTC ombudsman, OS were going to start do that she could not find ombudsman was noti transfer to the hospita On 7/22/21 at approxi (Administrator; ASM # Nursing), ASM #3, the	LTC) ombudsman was ransfer to the hospital. , an interview was (Other Staff Member) #1, sistant as the facility did not When asked the process term care ombudsman of SM #1 stated that in her will just hit a button that d send that generated report ng term care ombudsman. hat it looked like the not capturing residents who e hospital. OSM #1 stated re of this until survey. When heck system to ensure that reflected monthly to the SM #1 stated that the they bing that. OSM #1 confirmed d evidence that the LTC fied of Resident #48's al. imately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director orporate Nurse #1 were	F6	23			

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D: 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DATE	
		495330	B. WING			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	÷ 45	F	623			
	initially on 8/12/20 and diagnoses to include Mellitus, Hypertension Disorder. Resident #52's most of Set) was a Quarterly of Reference Date) of 6 (Brief Interview for Me 7 out of a possible 15 moderately cognitively some daily decision of Resident #52's Face 3 documented in part, a Last Qualifying Hospi 06/25/2020-06/29/202 Resident #52's Progra and are documented 6/25/2020 3:22 A.M.: 114/66 (blood pressur (respirations), 98.2 (te (oxygen saturations) a 3 liters via n/c (nasal	Sheet was reviewed and is as follows: tal Stay: 20 ess Notes were reviewed in part, as follows: resident vs (vital signs) re), 83 (pulse), 18					
	eval(evaluation) and t car plan sent with res called.	911 to Name (hospital) for x (treatment). be hold and ident. rp (representative) RP notified of resident's hospital).					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/18/2021 APPROVED . 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	PLE CONSTRUCTION G		(X3) DATE COMP	SURVEY
		495330	B. WING		-	07/2	22/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	LCENTER		1017 GEORGE WASHINGTO CHESAPEAKE, VA 2332			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623 F 625 SS=D	the local Ombudsman #55's discharge on 6/2 On 7/22/21 at 11:02 A conducted with OSM(regarding Ombudsman #52 hospital discharge stated, "I wasn't here started in September. binder and I did not se was notified of the dis asked when should th OSM #1 stated, "The notified of all discharg resident concerns." The facility policy titler Notice" last revised D reviewed and is docut Policy Interpretation at 4. A copy of the notic the State Long-Term (On 7/22/21 at 4:25 P. held with the ASM #1 #4 were the above inf to exit no further infor Notice of Bed Hold Po CFR(s): 483.15(d)(1) Notice of B §483.15(d)(1) Notice of B	Administrative Staff ed for documentation that a was notified of Resident 25/21. A.M. an interview was Other Staff Member)#1 in notification for Resident e on 6/25/21. OSM#1 when she was discharged, I I looked through the the ee where the Ombudsman charge." OSM#1 was ie Ombudsman be notified. Ombudsman should be les and if there are any d "Transfer or Discharge ecember 2016 was mented in part, as follows: and Implementation: e will be sent to the Office of Care Ombudsman. M. a pre-exit debriefing was , ASM #, ASM #3 and ASM ormation was shared. Prior mation was provided. Dicy Before/Upon Trnsfr 2) bed-hold policy and return- before transfer. Before a ars a resident to a hospital or	F 63	23			

Event ID: KQNC11

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /			(X3) DATE). 0938-0391 SURVEY 'LETED
		495330	B. WING			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA	AL CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	the resident or resider specifies- (i) The duration of the any, during which the return and resume res facility; (ii) The reserve bed p plan, under § 447.40 (iii) The nursing facilit bed-hold periods, whi paragraph (e)(1) of th resident to return; and (iv) The information s of this section. §483.15(d)(2) Bed-hot the time of transfer of hospitalization or ther facility must provide to resident representative specifies the duration described in paragrap This REQUIREMENT by: Based on staff intervia and clinical record rev facility staff failed to e policy was sent with of #48 upon transfer to t The findings included Resident #48 was add 1/13/20 and readmitted diagnoses that includ- heart failure, high bloc mellitus, high cholestor	provide written information to nt representative that e state bed-hold policy, if resident is permitted to sidence in the nursing rayment policy in the state of this chapter, if any; y's policies regarding ich must be consistent with is section, permitting a d pecified in paragraph (e)(1) of notice upon transfer. At f a resident for rapeutic leave, a nursing o the resident and the ve written notice which of the bed-hold policy ob (d)(1) of this section. f is not met as evidenced iew, facility document review view, it was determined that ensure the written bed hold one of 56 residents; Resident the hospital on 1/19/21. : mitted to the facility on ed on 1/24/21 with ed but were not limited to	F	625	5		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY LETED
		495330	B. WING			07/	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA				17 GEORGE WASHINGTON HIGHWAY NORTH HESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 625	 (minimum data set) as assessment with an A Reference Date) of 4/coded as being sever function scoring 00 out Interview for Mental S. Review of Resident # that she was sent out The following nursing part: "During nursing temp (temperature) at was noted to be 166/c Eyes fixed and dilated Resident started to diactivity. Oxygen appliminute) via nasal can resident noted to have continued convulsions transferred to (Name (Evaluation)." There was no evidend the SBAR (Situation, and recommendation written bed hold notic #48 upon transfer to to the On 7/21/21 at 10:04 at interview was attempt responsible party. She an interview. On 7/22/21 at 1:51 p.1 conducted with LPN (#2. Resident #48's curves attempt of the set of the	ARD (Assessment (2/21. Resident #48 was ely impaired in cognitive ut of 15 on the BIMS (Brief Status Exam). 48's clinical record revealed to the hospital on 1/19/21. note was documented in rounds, this writer noted that g profusely. No elevation in t this time. Blood pressure 144, BS (Blood Sugar) 188. d, non reactive to light. splay some seizure like ed at 2 lpm (liters per nulaUpon reassessment, e some facial distortion and s. 911 called and resident of hospital) for further eval. ce in the clinical record or on background, assessment) form dated 1/19/21 that the e was sent with Resident the hospital. a.m. and 12:04 p.m., an ted with Resident #48's e could not be reached for	F 6	25			

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/18/2021 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /				(X3) DATE	
		495330	B. WING				07/	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDICA				017 GEORGE WASHINGTON HIGHWAY NG CHESAPEAKE, VA 23323	ORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
F 625	stated that the facesh plan goals, and the be with the resident. Whe would be documented documents sent with the documents sent with the documented in a nurs we would know if these there is no evidence of documents were sent of transfer, LPN #2 st On 7/22/21 as of 3:00 sent Resident #48 our could not be reached On 7/22/21 at approxit (Administrator; ASM # Nursing), ASM #3, the of Nursing) and the C made aware of the ab information was prese Facility policy titled, "E documents in part, the transfer, written inform residents and the resi explains in detail: a. The rights and limit regarding bed holds; b. The reserve bed pa by the state plan (Med c. The facility per dier (non-Medicaid residen that state bed-hold per and	eet, medication list, care ed hold policy would be sent en asked if information sent d, LPN #2 stated that all the resident should be sing note. When asked how se documents were sent if of a nursing note or ng evidence that the above with the resident at the time ated, "We wouldn't know." 9 p.m., the nurse who had t to the hospital on 1/19/21 for an interview. imately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director orporate Nurse #1 were bove concerns. No further ented prior to exit. Bed-Holds and Returns" e following: "Prior to a nation will be given to the ident representative that tations of the resident ayment policy as indicated	F	525				

Facility ID: VA0043

If continuation sheet Page 50 of 78

CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	D: 11/18/2021 APPROVED D: 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>			(X3) DATE COMP	SURVEY PLETED
		495330	B. WING			07/:	22/2021
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 637 SS=D	CFR(s): 483.20(b)(2)(ssment After Signifcant Chg (ii) nin 14 days after the facility	F	637	7		
	determines, or should there has been a sign resident's physical or	have determined, that					
	means a major declin resident's status that	e or improvement in the will not normally resolve ntervention by staff or by					
	implementing standar interventions, that has one area of the reside	rd disease-related clinical s an impact on more than ent's health status, and ary review or revision of the					
	care plan, or both.) This REQUIREMENT	is not met as evidenced					
	by: Based on staff intervi	iew, facility document					
	review, and clinical re determined that facilit	-					
	assessment for one o	of 56 residents; Resident tted to hospice services.					
	The findings included	:					
	1/13/20 and readmitte						
	heart failure, high bloo	ed but were not limited to od pressure, diabetes erol, Alzheimer's disease,					
	(minimum data set) as assessment with an A						
	coded as being sever	/2/21. Resident #48 was rely impaired in cognitive ut of 15 on the BIMS (Brief Status Exam).					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATE	
		495330	B. WING			07/	22/2021
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 637	that he was put on ho The following current "Admission to receive (Name of Hospice Pro- Review of Resident # documented the follow Hospice. Resident rea to) family wishes and will experience death comfort. Advanced Di honored. Administer p Communicate with ho are indicated to the pl and services to be pro- hospice agency. Invol and decision making Manage pain and oth shceduled anagesicis supplies to be provide palliation and manage and related conditions Review of Resident # revealed that a signifi been completed for R completed MDS in Re the quarterly assessm On 7/22/21 at 11:48 a was conducted with F nurse. The facility dur MDS nurse onsite. W admitted to hospice s change MDS assess RN #1 stated, "It's su	48's clinical record revealed ospice services on 6/17/21. order was documented: a hospice services from ovider)." 48's care plan dated 6/21/21 wing: "Special Services- quires hospice R/T (related current conditionResident with dignity and physical irective wishes will be oain medication as ordered. ospice when any changes lan of care. Identify the care ovided by the facility and the lve responsible party in care to maximal potential. er uncomfortable symptoms a. Medication and medical ed by hospice as needed for ement of the terminal illness s" 48's MDS assessments cant change MDS had not cesident #48. The last esident #48's recored was nent dated 4/2/21. a.m., a telephone interview RN #1 , the regional MDS ring survey did not have a hen asked if a resident was ervices, if a significant ment would be completed, upposed to be." When asked ange assessment would be	F	637	7		

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			()(0)		0.00	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	· · ·	TE SURVEY MPLETED
		495330	B. WING		0	7/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY N CHESAPEAKE, VA 23323	IORTH	
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 637	Continued From page	e 52	F 63	7		
	admitted to hospice o	on 6/17/21; RN #1 stated that				
		assessment should have				
		/1/21 and then transcribed				
		. RN #1 stated the reason nge assessment had not				
		Resident #48 was because				
		ed on the census side to				
	hospice.					
	On $7/22/21$ at approx	imately 4:30 p.m., ASM				
		Member) #1, the interim				
		2, the DON (Director of				
		e ADON (Assistant Director				
	<i>,</i>	Corporate Nurse #1 were				
	information was prese	pove concerns. No further				
		Change in a Resident's				
		documents in part, the				
	physical or mental co	ant change in the resident's				
		ssment of the resident's				
		lucted as required by the				
		tions governing resident				
		outlined in the MDS RAI				
	(Resident Assessmer Manual."	nt Instrument) Instruction				
F 638		_east Every 3 Months	F 63	8		
SS=E						
	§483.20(c) Quarterly	Review Assessment				
	A facility must assess	a resident using the				
		ument specified by the State				
		S not less frequently than				
	once every 3 months	is not met as evidenced				
	by:					
	Based on clinical rec	ord roviow and staff				

Event ID: KQNC11

Facility ID: VA0043

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	
		495330	B. WING			07/	22/2021
NAME OF PF	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	L CENTER			017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 638	quarterly Minimum Da at least every 92 days The findings included During the course of t 7/22/21 many resident current MDS assessm Twenty residents were investigations. Eight quarterly review and t missing annual MDS The Quarterly assess non-comprehensive at that must be complete following the previous type. It is used to trac between comprehensive critical indicators of gu- resident's status are r Assessment Instrume dated October 2019, 0 On 7/20/21 at approxit Director of Nursing wa Coordinator and she s position was currently telephone the regional questions. On 7/21/21 at approxit Clinical Specialist pro MDS assessment, a t	's staff failed to complete a ata Set (MDS) assessment a for each resident. ", ", he survey 7/20/21 through ts reviewed didn't have a nent in the clinical record. e included in the survey for of the twenty were missing a wo of the twenty had assessments. "ment is an OBRA assessment for a resident ed at least every 92 days o OBRA assessment of any k a resident's status ive assessments to ensure radual change in a nonitored. (CMS Resident int Version 3.0 Manual, Chapter 2, page 2-33) "mately 4:10 p.m., the as asked to identify the MDS stated the MDS Coordinator of vacant but; they could al MDS Coordinator for any "mately 2:00 p.m., the vided a schedule of late	F	638			
	above findings were s						

Facility ID: VA0043

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	S FOR MEDICARE &			CONSTRUCTION		10. 0938-039	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				FE SURVEY MPLETED	
		495330	B. WING		0	7/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBF	RIER REGIONAL MEDICA	AL CENTER		017 GEORGE WASHINGTON HIGHWAY NC CHESAPEAKE, VA 23323	RTH		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 638	Continued From page	e 54	F 638				
	Specialist. The Clinical Specialist stated the Regional MDS Coordinator knew of the problem and was working towards addressing it. The Administrator stated a MDS Coordinator for the facility had been hired this week.						
F 640 SS=E	-	g Resident Assessments (4)	F 640				
	a facility completes a facility must encode t each resident in the f (i) Admission assess (ii) Annual assessme (iii) Significant change (iv) Quarterly review (v) A subset of items reentry, discharge, ar (vi) Background (face is no admission asse	ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, nd death. e-sheet) information, if there ssment.					
	after a facility comple a facility must be cap CMS System informa contained in the MDS standard record layou	itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident 6 in a format that conforms to uts and data dictionaries, dardized edits defined by					
	14 days after a facility assessment, a facility						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495330	B. WING			07/	22/2021
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA				017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 640	 (iv) Significant correction (v) Significant correction (vi) Quarterly review. (vii) A subset of items reentry, discharge, and (viii) Background (faction initial transmission of does not have an admost sy CMS, in the formation of a state which has by CMS, in the formation approved by CMS. This REQUIREMENT by: Based on clinical recomposition of the findings included On 7/20/21 at the endorreview of all offsite seconducted. CMS had the 12 resident approximation of the facility, four had be than 28 calendar days assessment wasn't in or transmitted to CMS's Resident Asset 	nt. e in status assessment. tion of prior full assessment. ion of prior quarterly a upon a resident's transfer, nd death. e-sheet) information, for an MDS data on resident that nission assessment. trmat. The facility must ormat specified by CMS or, an alternate RAI approved t specified by the State and t specified by the State and t is not met as evidenced ord review and staff 's staff failed to complete the sharge Minimum Data Set ithin the required timeframe from the facility. ; d of the day meeting, a elected residents was i identified 12 residents. Of ad been discharged from een discharged for more s yet the discharge MDS cluded in the clinical record S. essment Instrument Version tober 2019, Chapter 2, page	F	540			

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		MEDICAID SERVICES			OMB NO. 0938-		
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495330	B. WING		07/22/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY NOF CHESAPEAKE, VA 23323	NORTH		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLE		
F 640	within 14 days after th 14 calendar days) and	completed (item Z0500B) ne discharge date (A2000 + d the assessment must be	F 64	.0			
	submitted within 14 d completion date (Z05 days).						
	Director of Nursing wa Coordinator and she position was currently	imately 4:10 p.m., the as asked to identify the MDS stated the MDS Coordinator vacant but; they could al MDS Coordinator for any					
	Clinical Specialist pro discharge MDS asses	imately 2:00 p.m., the wided a schedule of ssment which hadn't been d among many others.					
F 657	above findings were s Administrator, Directo Specialist. The Clinica Regional MDS Coord and was working towa Administrator stated a facility had been hired Care Plan Timing and	or of Nursing and Clinical al Specialist stated the inator knew of the problem ards addressing it. The a MDS Coordinator for the d this week. I Revision	F 65	57			
SS=D	§483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as	ensive Care Plans orehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that ited to					

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/18/2021 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	
		495330	B. WING		07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		-
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 657	resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent prace the resident and the r An explanation must I medical record if the p and their resident rep not practicable for the resident's care plan. (F) Other appropriate disciplines as determi or as requested by the (iii)Reviewed and revi team after each asses comprehensive and q assessments. This REQUIREMENT by: Based on resident in facility document revior review, it was determ failed to inform one re care plan meetings ar conducting CP meetir The findings included Resident #7 was adm 1/18/19 and readmitted diagnoses that include End Stage Renal Disc Disorder. Resident #7's most re	e with responsibility for the responsibility for the and nutrition services staff. tricable, the participation of esident's representative(s). be included in a resident's participation of the resident resentative is determined e development of the staff or professionals in ined by the resident's needs e resident. ised by the interdisciplinary ssment, including both the quarterly review ' is not met as evidenced terview, staff interview, ew and clinical record ined that the facility staff esident representative of hd follow ups after ngs. : itted to the facility on ed on 11/25/20 with ed but were not limited to ease and Major Depressive	F 657	Past noncompliance: no plan of correction required.		

Facility ID: VA0043

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/18/2021 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE	
		495330	B. WING_			07/:	22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA	L CENTER			017 GEORGE WASHINGTON HIGHWAY NORTH		
				C	HESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page date) of 03/03/21. Res scoring 5 out of possil Interview for Mental S Resident #7's cognitiv making were severely On 7/21/21 at approxi interview was conduct the initial tour. She co recent invitation for a #7 stated, "What care On 7/22/21 at approxi call was made to Res Party) concerning car stated, "They used to then they stopped cal anyone from the facili updates concerning the outcomes. She stated On 07/22/21 at approxi interview was conduct Member/Social Service Resident #7's care pla "The care plan meetin on Tuesday and Thurs generated at the end residents if they want participate. Resident # own decision and cho attend the meetings. F	e 58 sident #7 was coded as ble 15 on the BIMS (Brief tatus exam). This indicated re abilities for daily decision r impaired. mately, 9:09 A.M., an ted with Resident #7 during uld not recall receiving a care plan meeting. Resident plan meeting." mately 10:56 A.M., a phone ident #7's RP (Responsible e plan meetings. She call me for the meetings ling me." She was asked if ty was calling her with he care plan meeting l, "No." ximately 11:04 AM an ted with OSM (Other Staff ces Worker) #1 concerning an meetings. She stated. togs are every three months sodays. The notices are of each month. I asked the		657			
	care plan meeting)." On 7/22/1 Surveyor re	I didn't document it (The eceived a copy of the care OSM #1. The document					

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DEPARTMENT OF HEA						FORM	D: 11/18/2021
CENTERS FOR MEDIC STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	ARE Q	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY LETED
		495330	B. WING			07/	22/2021
NAME OF PROVIDER OR SUPP	LIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GREENBRIER REGIONAL	MEDICA	L CENTER			17 GEORGE WASHINGTON HIGHWAY NORTH HESAPEAKE, VA 23323		
PREFIX (EACH D	EFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
6/10/21 at 1:0 of other partie well. According to H is her RP (Re According to t coded as a 5 Resident's co- making were On 7/22/21 at Resident #7 of care plan mee difference if m Ima do what I On 7/22/21 at information di shared with O reach out to th On 7/22/21 at meeting was of Director of Nu Nursing and v concerning th voiced. The facility sta each resident care plan, and representative making care p Past Non Cor	are plan 0 PM. F es was n Residen sponsib the MDS out of 19 gnitive a severely approxi- oncerni- etings. S hy sister want ar approxi- scussed SM #1. he reside approxi- conduct irsing, T vith the e above aff failed 's perso d that ea e were in olan dec npliance	meeting is scheduled on Refused to allow notification harked on the document as t #7's face sheet her sister le Party). 3. Resident #7 BIMS was 5 which indicated that abilities for daily decision r impaired. 5. Match indities	F 65	57			

Event ID: KQNC11

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/18/2021 1 APPROVED
STATEMENT C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE COMP	
		495330	B. WING		_	07/2	22/2021
NAME OF PF	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE	-	
GREENBR	IER REGIONAL MEDICA			017 GEORGE WASHINGT CHESAPEAKE, VA 233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	9 60	F 657				
F 657	Estimated completion The Identified Opport Improvement/Deficient Meeting 1. Immediate Correct by the deficient practic The IDT will be presend discipline that contribu- care. Proof of commu- the RP will be made in time of the care plan r time and date works f in the Matrix System. charted in Matrix of w attended. Proof of door resident and the RP. of after each assessment 2. Process/Steps to ic potential to be impact practice: Ensure care plan reflec Chart in matrix in com- Review assessment of 3. Measures put in to to ensure the deficient Social Services/Design meetings with resident Daily clinical meeting residents care confere approaching Charting all care plan	a date:08/30/21 unity for at Practice: Care Plan we Action for those affected ce: int to speak on each utes to the patient's holistic nication to the patient and in concerns of the date and meeting to ensure that the for them by way of charting Care Conference will be hat was discussed and who cuments provided to the Care Plan will be updated in is completed. dentify others having the ed by the same deficient ects resident current state cerns of care plan dates IDT place/systematic changes t practice does not recur gnee to schedule care plan its and their family/RP's with IDT to discuss ence that will be meetings and the attendee resident received a copy of	F 657				
		s of all care plan meeting					

Facility ID: VA0043

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			0.00.000			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		· · ·	TE SURVEY MPLETED
		495330	B. WING		0	7/22/2021
NAME OF PR	ROVIDER OR SUPPLIER		STI	REET ADDRESS, CITY, STATE, ZIP COI	DE	
GREENBR	RIER REGIONAL MEDICA	AL CENTER	-	17 GEORGE WASHINGTON HIGHWA IESAPEAKE, VA 23323	NY NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 686	Continued From page	9 61	F 686			
F 686 SS=D	Treatment/Svcs to Pre	event/Heal Pressure Ulcer	F 686			
	resident, the facility m (i) A resident receives professional standard pressure ulcers and d ulcers unless the indivi- demonstrates that the (ii) A resident with pre- necessary treatment a with professional stan promote healing, prev- new ulcers from deve This REQUIREMENT by: Based on observation document review, and was determined that the complete weekly would pressure ulcer* to the	re ulcers. hensive assessment of a bust ensure that- is care, consistent with les of practice, to prevent loes not develop pressure vidual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent dards of practice, to vent infection and prevent loping. is not met as evidenced in, staff interview, facility d clinical record review, it the facility staff failed to				
	localized damage to t tissue usually over a l to a medical or other present as intact skin be painful. The injury and/or prolonged pres	ar. The tolerance of soft				

Facility ID: VA0043

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D: 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE		
		495330	B. WING			07/22/2021		
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENBR	RIER REGIONAL MEDICA	L CENTER			1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 686	Continued From page	62	F	686				
	The findings included	:						
	10/17/20 with diagnos not limited to Anemia, insufficiency requiring pressure. Resident #5 (Minimum Data Set) a assessment with an A date) of 4/11/21. Resi being intact in cognitiv possible 15 on the BII Mental Status) exam. having one unstageat Review of Resident # that she was admitted unstageable pressure following was docume discharge summary d Hospitalist progress m	Assessment was a quarterly ARD (assessment reference dent #57 was coded as ve function scoring 15 out of MS (Brief Interview for Resident #57 was coded as one pressure ulcer (1). 57's clinical record revealed at from the hospital was an e ulcer to her right heel. The ented on the hospital ated 10/15/21: "						
	10/19/20 documented Location: Right heel. I Length: 2 Width 1.3. (No. Exudate: Modera TissueComments: F (medical doctor), A/O confusion, 0/10 pain I inflammatory stage, n viable tissue was esta dressed, (Name of RF aware of wound upda	evel. this wound is ecrotic tissue removed and ablished. wound cleaned and P (responsible party) made						

Facility ID: VA0043

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUCTION	_	(X3) DATE	
		495330	B. WING			07/2	22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
GREENBR	RIER REGIONAL MEDICA			1017 GEORGE WASHING CHESAPEAKE, VA 233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	as evidence by the Od Administration Record to "Rt (Right) heel: Pa on 10/29/20 through 3 Further review of Res revealed weekly wour 11/23/20. No other we notes from the wound found after 11/23/20 u following was docume weekly wound assess physician: "Unstageal right heel 2.3 x 2.7 x r adherent black necrot Wound status: Improv Betadine once daily." Further review of the and January, Februar revealed that staff cor order for Betadine dai Review of the next wo wound care physician the following: "Unstag right heel. Wound size measurable. Exudate adherent black necrot No Change. Dressing for 30 days. Reason f -infected heel necrosi There was no evidence wound assessments f physician or facility sta (3 weeks). The followi	being implemented by staff ctober TAR (Treatment d). This order was changed aint with betadine (3) daily" 3/16/21. Sident #57's clinical record and assessments until eekly wound assessments or d care physician could be until 3/4/21 (13 weeks). The ented on the 11/23/20 sment from the wound care ble due to necrosis of the not measurable. Thick tic tissue 100 percent. wed. Primary Dressing: November, December 2020 ry and March 2021 TARS ntinued to implement the ily. bund assessment from the n dated 3/4/21 documented geable due to necrosis of the e: 3.0 x 2.5 x not : None. 100 percent thick tic tissue. Wound Progress: g: Betadine apply twice daily for no debridement: Non is."	F 68				

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				RINTED: 11/18/2021 FORM APPROVED MB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(3) DATE SURVEY COMPLETED	
		495330	B. WING			07/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GREENBF	RIER REGIONAL MEDICA	L CENTER		1017 GEORGE WASHINGTON HIGH CHESAPEAKE, VA 23323	IWAY NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION E DATE
F 686	due to necrosis of the measurable. 100 percentissue. Wound progree Betadine apply twice of Review March 2021 T were implementing the until 4/15/21 when the "Santyl apply once date calcium alginate for 30 prep." Further review of the or revealed assessments was no evidence of an after 6/14/21 to currer recent weekly wound documented the follow 0.1 (Depth). Stage III Granulation Tissue. Wimproving: Improving. remained unchanged Review of Resident # orders for July 2021 roorders had not changer Further review of the staff we order for Santyl daily. Review of Resident # 10/22/20 documented #	right heel: 3.5 x 3.5 x not cent thick adherent necrotic ss: No change. Dressing: daily for 30 days." ARS revealed that staff e above orders for Betadine e order had changed to ily for 30 days; apply 0 days. Gauze roll. Skin weekly wound assessments s up until 6/14/21. There hy assessments conducted ht (5 weeks). The most assessment dated 6/14/21 ving: "Right heel. 1.5 x 1 x (4). Tissue Type: //ound healing status " The treatment for Santyl at that time. 57's current wound care evealed that her Santyl (5) ed. June and July 2021 TARS re implementing the above 57's current care plan dated I in part, the following: me of Resident #57's will tions through next review ssure ulcer for location,	F 686			

Facility ID: VA0043

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/18/2021 APPROVED). 0938-0391
STATEMENT C	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495330	B. WING			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBE				10	017 GEORGE WASHINGTON HIGHWAY NORTH		
OREERDI				С	HESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 686	Continued From page	65	F	686			
	Nursing). This intervie multiple requests for t above missing weekly Resident #57. When a identified wounds wer that wounds should b wound care physician responsible for asses care physician is not resident, ASM #2 stat wound care nurse wh wound assessments if a month and 1/2 ago. floor nurses should dr and that they should dr weekly. ASM #2 state then call on her (the I the wound for every m stated that she would well. ASM #2 stated th nursing staff to docum of stages and measur system (the clinical re management documen nursing staff were cor through current to sta Resident #57, ASM # When asked where th located for these date thought her staff were were not. When asker expected to documen measurement assess	#2, the DON (Director of ew was conducted after he facility to obtain the a wound assessments for asked how often already e assessed, ASM #2 stated e assessed weekly by the but when asked who was sing wounds if the wound present or cannot see the ed that they used to have a o was doing all the weekly but that she had left the job ASM #2 stated that the ress the wounds per order measure the wounds do that the nurses should DON) to come in and stage esident wound. ASM #2 then measure the wound as hat she then expected her nent her own observations rements in the computer for d) on a weekly wound ent. When asked if her ning to get her from 6/14/21 ge and measure wounds on 2 stated that they were. the documentation was is, ASM #2 stated that she is documenting but that they d why her staff were					
		and they were supposed to er. ASM #2 handed this					

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	-	ID HUMAN SERVICES			FOF	ED: 11/18/2021
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DAT	O. 0938-0391 E SURVEY IPLETED
		495330	B. WING		0	7/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CO) DE	
GREENBE			1	017 GEORGE WASHINGTON HIGHW	AY NORTH	
0			C	CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 686	June 20th through Jul This form had a mease Resident #57's right h Stage 3." There was of measurement was ob- description of the wou #2 also handed this w Management Meeting July 17th. The form had documented for Resid x 1.5 x 0.1 cm" No sta was no date showing was obtained. There w wound during this tim dates of when these r obtained, ASM #2 state the exact dates the m that were located on t When asked about th missing weekly woun 11/23/21 through 3/4/ 4/7/21; ASM #2 state look for those. When weekly wound assess the purpose was to se progress with healing to see if a treatment/r needed to be changed On 7/22/21 at approx Corporate Nurse #1, s had arrived back from going to make staff do and assessment to se heel had declined or i the wound care physion weekly basis for physion	gement Meetings" for dates by 3rd (two week period). surement documented for heel of "1.5 x 1.5 x 0.2. no date showing when this trained. There was no and during this time. ASM writer an "At risk g" for date July 4th through ad a measurement dent #57's right heel of "2.5 age was documented. There when this measurement was no description of the e. When asked the exact measurements were ted that she could not recall reasurements were ted that she could not recall reasurements were obtained the "At Risk Meeting" forms. e location of all other d measurements from 21 and 3/12/21 through d that she would have to asked the purpose of sments, ASM #2 stated that ee if the wound was making or to see if it was declining, medication/intervention d to promote healing.	F 686			

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					FO	ED: 11/18/2021 RM APPROVED
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DA	NO. 0938-0391 TE SURVEY MPLETED
		495330	B. WING		o	7/22/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON H CHESAPEAKE, VA 23323	IIGHWAY NORTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE TO THE APPROPRIATE DIENCY)	(X5) COMPLETION DATE
F 686	when the wound care rounds. When asked wound care physician #57's dialysis, the Co she was going to star On 7/22/21 at approxi- care observation was (Administrative Staff M (Assistant Director of (Licensed practical nu- assigned nurse. Resid to remain a Stage thre following measureme cm (centimeters); indi wound had not declin no evidence of escarp On 7/22/21 at approxi (Administrative Staff M Administrator; ASM # Nursing), ASM #3, the of Nursing) and the C made aware of the ab- information was prese policy that could be p performing wound care (1) Unstageable prese tissue loss in which th covered by slough (ye brown) and/or eschar wound bed. Further d slough and/or eschar base of the wound, th stage, cannot be dete adherent, intact witho	would always be at dialysis physician would make her if they should coordinate the 's schedule with Resident rporate Nurse #1 stated that t working on a plan for that. imately 3:00 p.m., wound conducted with ASM Member) #3, the ADON Nursing) and LPN urse) #1, Resident #57's dent #57's wound appeared ee; with no depth. The nts were recorded: 1.4 x 1 icating that her right heel ed since 6/14/21. There was o (necrotic) tissue). imately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director orporate Nurse #1 were pove concerns. No further ented prior to exit. The only rovided was a policy on re. sure ulcer: Full thickness he base of the ulcer is ellow, tan, gray, green or (tan, brown or black) in the escription: Until enough is removed to expose the e true depth, and therefore	F 686			

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CENTER	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	D: 11/18/2021 MAPPROVED D: 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í			(X3) DATE SURVEY COMPLETED		
		495330	B. WING			07/	22/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
GREENB	RIER REGIONAL MEDICA				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 686	This information was Pressure Ulcer Adviso http://www.npuap.org. (2) Skin-Prep Protectiis a liquid film-forming protective film to help removal of tapes and protects fragile skin a removal trauma. This from the website: www (3) Betadine is used to infection in minor cuts information was obtai https://betadine.com/w (4) Stage three pressure loss. Subcutant bone, tendon or musc may be present but do tissue loss. May inclut tunneling. Further des stage III pressure ulce location. The bridge of malleolus do not have stage III ulcers can be of significant adiposity deep stage III pressur visible or directly palp obtained from: Nation Panel website at http: (5) Santyl- *SANTYL@FDA-approved active continuously removes wounds at the micros	d should not be removed. obtained from: National ory Panel website at /pr2.htm. ive Barrier Wipes: Skin-Prep g dressing that forms a reduce friction during films. The Skin Prep also nd reduces adhesive information was obtained w.allegromedical.com to help treat and prevent s, scrapes and burns. This ned from what-is-betadine/. ure ulcer: Full thickness eous fat may be visible but cle are not exposed. Slough oes not obscure the depth of de undermining and scription: The depth of a er varies by anatomical of the nose, ear, occiput and e subcutaneous tissue and e shallow. In contrast, areas y can develop extremely re ulcers. Bone/tendon is not pable. This information was nal Pressure Ulcer Advisory t//www.npuap.org/pr2.htm.	F	686				

Facility ID: VA0043

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		MEDICAID SERVICES				0.0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495330	B. WING		07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA	AL CENTER		1017 GEORGE WASHINGTON HIGHWAY NOF CHESAPEAKE, VA 23323	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIOI DATE
F 686	Continued From page	9 69	F 68	36		
	allowing granulation to epithelialization to occ (<http: td="" www.santyl.co<=""><td>cur.</td><td></td><td></td><td></td><td></td></http:>	cur.				
F 689 SS=D	Free of Accident Haza	ards/Supervision/Devices	F 68	99		
	as free of accident ha §483.25(d)(2)Each re supervision and assis accidents. This REQUIREMENT by: Based on observation record review, the fac the resident's call bell					
		ginally admitted to the facility been discharged from the agnoses included;				
	(ARD) of 3/22/21 code completing the Brief I (BIMS) therefore a sta It revealed the residen names and faces, roc a nursing home. The	assessment reference date ed the resident as not nterview for Mental Status aff interview was conducted. nt recalls the season, staff om location and that he is in				

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	-	D HUMAN SERVICES				FORM	D: 11/18/2021
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY LETED
		495330	B. WING			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBF	RIER REGIONAL MEDICA	L CENTER			017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 689	the resident was code with bathing, extensive with personal hygiene assistance with transf supervision after set-to On 7/20/21 at approxi #39 was observed in within reach. The ress call bell but was unab call bell with the push On 7/21/21 at approxi #39 was again observed observed to be conner resident was asked to Resident #39 reached unable to obtain the of two call bell buttons withe other white. The make an observation status. There was signage of read; ensure the call f mat is beside the bed Review of Resident # problem dated 4/7/21 resident will remain fr related to falls through included; keep the can times. An interview was con- Manager on 7/21/21 a The Unit Manager status	"G" (Physical functioning) ed as requiring total care e assistance of one person and bathing, limited fers and toileting and up with eating. Imately 1:35 p.m., Resident bed without the call bell ident was asked to push the le to locate the end of the button. Imately 10:50 a.m., Resident ved in bed. The call bell was acted in the wall and the o activate the call bell. d for the call bell but was all button. Beneath the bed vere observed. One was red, Unit Manager was asked to of the resident's call bell the resident's wall which bell is within reach and the when the resident is in bed. 39's care plan was a Fall . The goal read; The ee from serious injury n 7/7/21. The interventions Il light within reach at all	F	589			

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	-					FORM): 11/18/2021 1 APPROVED
STATEMENT (S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION		(X3) DATE COMP	
		495330	B. WING		_	07/:	22/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	-	
GREENBF	RIER REGIONAL MEDICA			017 GEORGE WASHINGT HESAPEAKE, VA 233			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	resident's call bell from placed it to the reside the bed linen. The Ur he wasn't aware of the after reading it he felt would be removed. On 7/22/21 at approxi- findings were shared Director of Nursing an Clinical Specialist stat new in the role and sh receiving the informat also stated the reside reach at all times. RN 8 Hrs/7 days/Wk, CFR(s): 483.35(b)(1)- §483.35(b) Registered §483.35(b)(1) Except paragraph (e) or (f) of must use the services least 8 consecutive he §483.35(b)(2) Except paragraph (e) or (f) of must designate a regi director of nursing on §483.35(b)(3) The dir as a charge nurse on average daily occupa This REQUIREMENT by: Based on review of fa interview, the facility's	Manager retrieved the m beneath the bed and nt's left side attaching it to nit Manager further stated e signage on the wall but it was inappropriate and it imately 4:00 p.m., the above with the Administrator, nd Clinical Specialist. The ted the Unit Manager was ne was sure he appreciated cion. The Clinical Specialist nt's call bell should be within Full Time DON -(3) d nurse when waived under this section, the facility s of a registered nurse for at cours a day, 7 days a week. when waived under this section, the facility stered nurse to serve as the	F 689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495330		495330	B. WING		07/22/2021	
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBRIER REGIONAL MEDICAL CENTER				1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 727	hours each day		F 727			
F 761 SS=D	 hours each day The findings included: During review of staffing it was identified that a Registered Nurse (RN) had not worked at least 8 consecutive hours a day, 7 days a week over a six month timespan. The deficits were on the weekends and major holidays. An interview was conducted with the previous staffing coordinator. After a careful review of the schedules she concluded the RN coverage wasn't available 8 consecutive hours a day, 7 days a week. On 7/22/21 at approximately 4:00 p.m., the above findings were shared with the Administrator, Director of Nursing and Clinical Specialist. The Clinical Specialist stated she wasn't aware of the RN staffing concerns. The Director of Nursing stated that was in the past but the review revealed as recent as 7/11/21 and 7/17/21, a RN didn't work 8 consecutive hours. Label/Store Drugs and Biologicals 		F 761			
	,	f Drugs and Biologicals rdance with State and				

Event ID: KQNC11

Facility ID: VA0043

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· , ,			(X3) DATE SUR COMPLETE	
495330		B. WING _			07/22/2021		
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1(017 GEORGE WASHINGTON HIGHWAY NORTH		
GREENBRIER REGIONAL MEDICAL CENTER			С	HESAPEAKE, VA 23323			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 761	biologicals in locked of temperature controls, personnel to have acco §483.45(h)(2) The fact locked, permanently a storage of controlled of the Comprehensive D Control Act of 1976 and abuse, except when t package drug distribut quantity stored is mini- be readily detected. This REQUIREMENT by: Based on observation document review, it w staff failed to appropri- one of four facility me medication cart. The findings included On 7/21/21 at 11:56 a hall medication cart w drawer to the medicat cup full of eight pills th asked the nurse (LPN #3 who the pills belong the pills belonged to a take them right away this resident wanted h room but that she did appropriate. LPN #3 s in the top drawer beca attempt to give him hi asked if his medication	lity must store all drugs and compartments under proper and permit only authorized cess to the keys. clility must provide separately affixed compartments for drugs listed in Schedule II of orug Abuse Prevention and nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can is not met as evidenced in, staff interview and facility tately store medications on dication carts; the 400 hall	F	761			
	asked if his medicatio						

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				LE CONSTRUCTION			
TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	(X3) DATE SURVEY COMPLETED				
		495330	B. WING	07/22/2021			
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE				
GREENBRIER REGIONAL MEDICAL CENTER				1017 GEORGE WASHINGTON HIGHWAY NOR CHESAPEAKE, VA 23323	ŧТН		
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE		
F 761	Continued From page	e 74	F 76	1			
	"Yes." LPN #3 stated the cup of pills in the medication cart.	that she shouldn't have left first drawer of the					
	(Administrative Staff Administrator; ASM # Nursing), ASM #3, th of Nursing) and the C	imately 4:30 p.m., ASM Member) #1, the interim 2, the DON (Director of e ADON (Assistant Director corporate Nurse #1 were pove concerns. No further ented prior to exit.					
	A policy regarding me be provided.	edication storage could not					
F 814 SS=D	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4)		F 81	4			
	properly. This REQUIREMENT by: Based on observatio facility staff failed to e	e of garbage and refuse is not met as evidenced n and staff interview, the ensure that the garbage the from garbage and refuse.					
	The findings included	0 0					
	of the outside dumps Dietary Manager. Four dumpsters were dumpster area. The with the following: The bottom of the du	eximately 11:40 a.m., a tour ter area was made with the observed outside in the smallest dumpster observed mpster was coming apart d gloves, trash coming from					
	the opening (front and Surrounding the dum	d back of the dumpster). pster on the ground (front gloves, used briefs, paper,					

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495330	B. WING			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBRIER REGIONAL MEDICAL CENTER					1017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 814	observed flying aroun that was coming from where it was coming a was the following: 3 o with standing water of scattered all over the The Dietary Manager responsible for ensuri free from garbage and must be honest, I real On 07/20/21 at appro- dumpster area was to Director. He stated, " area looked like that (everywhere." The Ma stated, "I had no idea apart; it need to be re Maintenance Director trash/dumpster Comp was a dumpster that v to be replaced as soo Maintenance Director replied, "They will be the small dumpster the On 07/21/21 at appro- Maintenance Director room and stated, (nar just delivered a new o dumpster that was co The Administrator and was informed during t approximately 1:45 p. responsible for keepir	d. Flies and nets were d the garbage and refuse the bottom of dumpster apart. Behind the dumpster ld ripped/torn mattresses in the top mattress and trash back area near the fence. was asked, "Who is ing the dumpster area is d refuse, she replied, "I lly don't know." ximately 1:10 p.m., the ured with the Maintenance I had no idea the dumpster trash, debris and refuse) aintenance Director also the dumpster was coming placed right away." The called (name of any), informed them there was coming apart and need n as possible. After the got off the phone, he here to tomorrow to replace at is falling apart." ximately 2:05 p.m., the came into the conference ne of dumpster company) lumpster and removed the ming apart. d Director of Nursing (DON) he debriefing on 07/21/21 at m. When asked who is ing the dumpster area free e, the Administrator replied,	F	814			

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		D HUMAN SERVICES MEDICAID SERVICES			FORM	D: 11/18/2021 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	
495330		495330	B. WING		07/22/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENBRIER REGIONAL MEDICAL CENTER				1017 GEORGE WASHINGTON HIGHWAY NO CHESAPEAKE, VA 23323	RTH	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 814	Continued From page rounds of the dumpste		F 81	4		
	and Refuse Disposal 10/2017. Policy statement: Foo	ed, "Food-Related Garbage with a revision date of d-related garbage and f in accordance with current				
F 947 SS=D	but not limited to: 5. Garbage and refuse will be store in a mani- pets. 7. Outside dumpster services will be kept of surrounding litter. Required In-Service T	raining for Nurse Aides	F 94	7		
	aides. In-service training mu §483.95(g)(1) Be suff continuing competence be no less than 12 ho §483.95(g)(2) Include training and resident a §483.95(g)(3) Addres determined in nurse a and facility assessme address the special no determined by the face	icient to ensure the ce of nurse aides, but must urs per year. dementia management abuse prevention training. s areas of weakness as iides' performance reviews nt at § 483.70(e) and may eeds of residents as				

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/18/2021 APPROVED D: 0938-0391
STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495330	B. WING			07/	22/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GREENB	RIER REGIONAL MEDICA	L CENTER			017 GEORGE WASHINGTON HIGHWAY NORTH CHESAPEAKE, VA 23323		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 947	address the care of th This REQUIREMENT by: Based on review of fa interviews, the facility of two Certified Nurse training included dem resident abuse preven The findings included A review was conduct program. The training dementia management prevention training. On 7/21/21 at approxi interview was conduct stated she had receive dementia residents and stating best practice in working with resident' without behaviors. Cl stating some types of resident was not com observation was made provided care to a resise behaviors. No concerner stated education is alw On 7/22/21 at approxit findings were shared Director of Nursing an Clinical Specialist states	Initive impairments, also according to the cognitively impaired. Is not met as evidenced accility documents and staff is staff failed to ensure two exides (CNA) in-service entia management and ntion training. Is the don two CNA's training grecords didn't include int and resident abuse imately 11:40 a.m., an ted with CNA #1. CNA #1 ed training in working with ad she was capable of information regarding s with dementia with or NA #1 was also capable of abuse and what to do if a pliant with care. An e on 7/21/21 as CNA #1 sident with dementia and ins were observed. CNA #1 ways welcomed. Imately 4:00 p.m., the above with the Administrator, ad Clinical Specialist. The ted the facility was in the g and boosting morale and	F	947			

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