STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495142	A. BUILDING _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness Survey was conducted 4/12/22 through 4/14/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	This Plan of correction is respectfully submitted as evidence of alleged compliance. This submission is not an admission that the deficiencies existed or that we are in agreement with them. It is an affirmation that corrections to the areas cited have been made and the facility is in compliance with participation requirements.	
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 4/12/22 through 4/14/22. Two complaints (VA00053579 unsubstantiated and VA00053564 unsubstantiated) were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 176 bed certified facility was 120 at the time of the survey. The survey sample included forty current residents and five closed record reviews.	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).	F 578	**F578/12VAC5-371-240(C)(10)– Request/Refuse/Discontinue Treatment; Formulate Advanced Directive** 1.) Advance Directives have been formally discussed with residents #110, #47, #50, #61, #111, and #58 and their medical records have been updated to reflect their choices. Evergreen Heath and Rehab has identified that all residents are at risk from not having a discussion regarding their advance directives.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mon Pres | TITLE: Administrator | (X6) DATE: 5/2/22

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

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F 578	Continued From page 1 (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to evidence discussion of an advance directive for six of 45 residents in the survey sample, Resident #110, #47, #50, #111, #61 and #58 The findings include: 1. The facility staff failed to evidence documentation of a discussion regarding advance directives for Resident #110 (R110).	F 578	2.) Administrator/designee audited residents who admitted in the last 90 days to ensure that advance directives have been discussed with them. Any variances have been addressed immediately via care plan meetings, and discussions have been held and advance directives have been updated to reflect the individual choices of all current residents. 3.) The Administrator/designee has in-serviced the Social Services Director and Nursing/Clinical leadership staff regarding the importance of discussing advance directives with residents at care-plan meetings. The in-service includes, but not limited to, the importance of accurate advance directive orders for all residents, completing the POST form, and the acceptable timeframe to begin discussing advance directives after admission to the facility.	

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F 578	Continued From page 2 On the most recent MDS (minimum data set) a quarterly assessment, with an ARD (assessment reference date) of 3/15/2022, the BIMS (brief interview for mental status) was not coded correctly. On the prior MDS assessment, an admission assessment, with an ARD of 12/13/2021, the resident scored a 13 out of 15 on the BIMS score indicating the resident not cognitively impaired for making daily decisions. Further review of the clinical record failed to evidence any documentation regarding a discussion regarding an advance directive. The comprehensive care plan dated 12/18/2021, documented in part, "Resident has established Do not resuscitate (DNR) order." The "Interventions" documented in part, "Educate resident and family on choices in regard to advance directives/code status. An interview was conducted on 4/13/2022 at 12:30 p.m. with OSM (other staff member) #3, the social services assistant. When asked whose responsibility it was for obtaining a copy of the advance directive and putting it in the clinical record, OSM #3 stated [name of social worker - OSM #4] keeps a log of what the resident's code status is. When asked what the advance directive is, OSM #3 stated it's a more detailed specific requests for end of life. When asked where it is documented that the resident have been offered to develop an advance directive, OSM #3 stated during the care plan meetings, the code status is reviewed. When asked the process for a new admission to determine if they have an advance directive, OSM #3 stated when the resident is admitted that is when we find out the code status and if they have an advance directive. When	F 578	4.) The Administrator/designee will audit all newly admitted residents weekly for 6 weeks to ensure that advance directives discussion has been initiated and that the resident medical record reflects their individual choices. The Administrator/designee will meet with social services director and Nursing leadership weekly for 6 weeks to review all previous weeks admissions and ensure that advance directive orders are completed and accurately reflect resident choices. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be taken. The Administrator/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 578	Continued From page 3 asked if there is no advance directive, do you offer to provide them information on how to develop an advance directive, OSM #3 stated only if the resident and or family request it, we don't offer the information to them to my knowledge. When asked when a resident is admitted and has an advance directive, where does it go, OSM #3 stated it is put into the record. When asked if she would document if the resident has or doesn't have an advance directive, OSM #3 stated if the resident has one it is scanned into the record. When asked on admission does the facility offer information on how to initiate an advance directive, OSM #3 stated, no only if they ask do we provide any information. OSM #3 reviewed the record for R110. OSM #3 stated there was no advance directive on file. An interview was conducted on 4/13/2022 at 12:50 p.m. with OSM #4, the social worker. When asked the process for obtaining an advance directive for a new resident, OSM #4 stated on admission the facility asks for a copy of the advance directive and scans it into the chart. When asked if a resident does not have one, what you do, do you offer information on developing an advance directive, OSM #4 stated if the resident and/or family is interested then we provide them the information. When asked if it is something you routinely do or do you wait for the resident and/or family to initiate, OSM #4 stated I don't initiate it. If they don't who how to develop an advance directive then we direct them. When asked should every resident have documentation of the discussion of advance directive, OSM #4 stated if it was discussed then it would be documented. A DDNR (durable do not resuscitate form) was reviewed with OSM #4. OSM #4	F 578		

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F 578	Continued From page 4 stated that means they don't want CPR (cardiopulmonary resuscitation). When asked if that is an advance directive, OSM #4 stated no, an advance directive is much more information than that. OSM #4 stated the two are not the same. The residents were discussed that we did not see an advance directive or evidence information was provided on advance directives, should that be done for all residents, OSM #4 stated, we could offer that. A social worker's note in the clinical record was reviewed. The note documented, the resident will remain DNR, when asked if that include the advance directive discussion, OSM #4 stated, no, it's only the code status. When a new resident is admitted, are you the one that requests the advance directive, OSM #4 stated [name of admissions director - OSM #5]. The facility policy, "Advance Directives" documented in part, "Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so....Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives....If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. a. The resident will be given the option to accept or decline the assistance, and care will not be contingent on either decisions. b. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance."	F 578		

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F 578	Continued From page 5 ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/13/2022 at 5:15 p.m. No further information was provided prior to exit. 2. The facility staff failed to evidence documentation of a discussion regarding advance directives for Resident #47 (R47) On the most recent MDS, a quarterly assessment, with an ARD of 2/1/2022, the resident was coded as having both short and long term memory problems and was severely cognitively impaired for making daily decisions. Further review of the clinical record failed to evidence any documentation regarding a discussion regarding advance directive. The comprehensive care plan dated, 4/15/2020, documented in part, "Focus: Resident is a full code." The "Interventions" documented in part, "Educate resident and family on choices in regard to advance directives/code status." The facility provided a document dated 9/21/2019, that documented. "I [R47] [Date of birth] I give my children, son [name of son] and my daughter, [name of daughter], I give them power of attorney to speak on my behalf." This document was signed and notarized. There was no mention of the wishes for advance directives.	F 578		

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F 578	Continued From page 6 An interview was conducted on 4/13/2022 at 12:30 p.m. with OSM (other staff member) #3, the social services assistant. When asked whose responsibility it was for obtaining a copy of the advance directive and putting it in the clinical record, OSM #3 stated [name of social worker - OSM #4] keeps a log of what the resident's code status is. When asked what the advance directive is, OSM #3 stated it's a more detailed specific requests for end of life. When asked where it is documented that the resident have been offered to develop an advance directive, OSM #3 stated during the care plan meetings, the code status is reviewed. When asked the process for a new admission to determine if they have an advance directive, OSM #3 stated when the resident is admitted that is when we find out the code status and if they have an advance directive. When asked if there is no advance directive, do you offer to provide them information on how to develop an advance directive, OSM #3 stated only if the resident and or family request it, we don't offer the information to them to my knowledge. When asked when a resident is admitted and has an advance directive, where does it go, OSM #3 stated it is put into the record. When asked if she would document if the resident has or doesn't have an advance directive, OSM #3 stated if the resident has one it is scanned into the record. When asked on admission does the facility offer information on how to initiate an advance directive, OSM #3 stated, no only if they ask do we provide any information. OSM #3 reviewed the record for resident. OSM #3 stated there was no advance directive on file. An interview was conducted on 4/13/2022 at 12:50 p.m. with OSM #4, the social worker. When	F 578		

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F 578	Continued From page 7 asked the process for obtaining an advance directive for a new resident, OSM #4 stated on admission the facility asks for a copy of the advance directive and scans it into the chart. When asked if a resident does not have one, what you do, do you offer information on developing an advance directive, OSM #4 stated if the resident and/or family is interested then we provide them the information. When asked if it is something you routinely do or do you wait for the resident and/or family to initiate, OSM #4 stated I don't initiate it. If they don't who how to develop an advance directive then we direct them. When asked should every resident have documentation of the discussion of advance directive, OSM #4 stated if it was discussed then it would be documented. A DDNR (durable do not resuscitate form) was reviewed with OSM #4. OSM #4 stated that means they don't want CPR (cardiopulmonary resuscitation). When asked if that is an advance directive, OSM #4 stated no, an advance directive is much more information than that. OSM #4 stated the two are not the same. The residents were discussed that we did not see an advance directive or evidence information was provided on advance directives, should that be done for all residents, OSM #4 stated, we could offer that. A social worker's note in the clinical record was reviewed. The note documented, the resident will remain full code, when asked if that includes the advance directive discussion, OSM #4 stated, no, it's only the code status. When a new resident is admitted, are you the one that requests the advance directive, OSM #4 stated [name of admissions director - OSM #5]. When shown the handwritten, notarized document above, OSM #4 was asked if that was an advance directive, OSM #4 stated, no.	F 578		

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F 578	Continued From page 8 ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/13/2022 at 5:15 p.m. No further information was provided prior to exit. 3. The facility staff failed to evidence documentation of a discussion regarding advance directives for Resident # 50. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/02/2022, the resident scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. The comprehensive care plan for (R50) dated 04/13/2020 documented in part, "Focus: Resident has established Do not resuscitate (DNR) order. Date Initiated: 04/13/2020." Under "Interventions" it documented in part, "Educate resident and family on choices in regard to advance directives/code status. Date Initiated: 04/13/2020." Review of (R50's) clinical record failed to evidence documentation of an advance directive. An interview was conducted on 4/13/2022 at 12:30 p.m. with OSM (other staff member) #3, the social services assistant. When asked who's responsibility it was for obtaining a copy of the advance directive and put it in the clinical record, OSM #3 stated [name of social worker - OSM #4] keeps a log of what the resident's code status is.	F 578		

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F 578	Continued From page 9 When asked what the advance directive is, OSM #3 stated it's a more detailed specific requests for end of life. When asked where it is documented that the resident have been offered to develop an advance directive, OSM #3 stated during the care plan meetings, the code status is reviewed. When asked the process for a new admission to determine if they have an advance directive, OSM #3 stated when the resident is admitted that is when we find out the code status and if they have an advance directive. When asked if there is no advance directive, do you offer to provide them information on how to develop an advance directive, OSM #3 stated only if the resident and or family request it, we don't offer the information to them to my knowledge. When asked when a resident is admitted and has an advance directive, where does it go, OSM #3 stated it is put into the record. When asked if she would document if the resident has or doesn't have an advance directive, OSM #3 stated if the resident has one it is scanned into the record. When asked on admission does the facility offer information on how to initiate an advance directive, OSM #3 stated, no only if they ask do we provide any information. OSM #3 reviewed the record for (R50). OSM #3 stated there was no advance directive on file. An interview was conducted on 4/13/2022 at 12:50 p.m. with OSM #4, the social worker. When asked the process for obtaining an advance directive for a new resident, OSM #4 stated on admission the facility asks for a copy of the advance directive and scan it into the chart. When asked if a resident does not have one, what do you do, do you offer information on developing an advance directive, OSM #4 stated if the resident and/or family is interested then we	F 578		

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F 578	Continued From page 10	F 578		

provide them the information. When asked if it is something you routinely do or do you wait for the resident and/or family to initiate, OSM #4 stated I don't initiate it. If they don't know how to develop an advance directive then we direct them. When asked should every resident have documentation of the discussion of advance directive, OSM #4 stated if it was discussed then it would be documented. A DDNR (durable do not resuscitate form was reviewed with OSM #4. OSM #4 stated that means they don't want CPR (cardiopulmonary resuscitation). When asked if that is an advance directive, OSM #4 stated no, an advance directive is much more information than that. OSM #4 stated the two are not the same. The residents were discussed that we did not see an advanced directive or evidence information was provided on advance directives, should that be done for all residents, OSM #4 stated, we could offer that. A social worker's note in the clinical record was reviewed. The note documented, the resident will remain DNR, when asked if that include the advance directive discussion, OSM #4 stated, no, it's only the code status. When a new resident is admitted, are you the one that requests the advance directive, OSM #4 stated [name of admissions director - OSM #5].

An interview was conducted with OSM #5, the admissions director, on 4/13/2022 at 1:01 p.m. When asked if the advance directive is part of the admission paperwork, OSM #5 reviewed the admission paperwork and stated it was not part of the admission paperwork. Upon admission to you request a copy of the advance directive, OSM #5 stated she believed it was the social workers that do that.

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F 578	Continued From page 11 On 04/13/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing and ASM # 4, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit 4. The facility staff failed to evidence documentation of a discussion regarding advanced directives for Resident # 111. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/23/2022, the resident scored 7 (seven) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. The comprehensive care plan for (R111) dated 03/26/2022 documented in part, "Focus: Resident is a full code. Date Initiated: 03/26/2022." Under "Interventions" it documented in part, "Initiate (CPR) Cardiopulmonary resuscitation as ordered. Date Initiated: 03/26/2022." Review of (R111's) clinical record failed to evidence documentation of an advance directive. An interview was conducted on 4/13/2022 at 12:30 p.m. with OSM (other staff member) #3, the social services assistant. When asked who's responsibility it was for obtaining a copy of the advance directive and put it in the clinical record, OSM #3 stated [name of social worker - OSM #4] keeps a log of what the resident's code status is.	F 578		

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EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 12 When asked what the advance directive is, OSM #3 stated it's a more detailed specific requests for end of life. When asked where it is documented that the resident have been offered to develop an advance directive, OSM #3 stated during the care plan meetings, the code status is reviewed. When asked the process for a new admission to determine if they have an advance directive, OSM #3 stated when the resident is admitted that is when we find out the code status and if they have an advance directive. When asked if there is no advance directive, do you offer to provide them information on how to develop an advance directive, OSM #3 stated only if the resident and or family request it, we don't offer the information to them to my knowledge. When asked when a resident is admitted and has an advance directive, where does it go, OSM #3 stated it is put into the record. When asked if she would document if the resident has or doesn't have an advance directive, OSM #3 stated if the resident has one it is scanned into the record. When asked on admission does the facility offer information on how to initiate an advance directive, OSM #3 stated, no only if they ask do we provide any information. OSM #3 reviewed the record for (R111). OSM #3 stated there was no advance directive on file. An interview was conducted on 4/13/2022 at 12:50 p.m. with OSM #4, the social worker. When asked the process for obtaining an advance directive for a new resident, OSM #4 stated on admission the facility asks for a copy of the advance directive and scan it into the chart. When asked if a resident does not have one, what do you do, do you offer information on developing an advance directive, OSM #4 stated if the resident and/or family is interested then we	F 578		

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F 578	Continued From page 13 provide them the information. When asked if it is something you routinely do or do you wait for the resident and/or family to initiate, OSM #4 stated I don't initiate it. If they don't know how to develop an advance directive then we direct them. When asked should every resident have documentation of the discussion of advance directive, OSM #4 stated if it was discussed then it would be documented. A DDNR (durable do not resuscitate form was reviewed with OSM #4. OSM #4 stated that means they don't want CPR (cardiopulmonary resuscitation). When asked if that is an advance directive, OSM #4 stated no, an advance directive is much more information than that. OSM #4 stated the two are not the same. The residents were discussed that we did not see an advanced directive or evidence information was provided on advance directives, should that be done for all residents, OSM #4 stated, we could offer that. A social worker's note in the clinical record was reviewed. The note documented, the resident will remain DNR, when asked if that include the advance directive discussion, OSM #4 stated, no, it's only the code status. When a new resident is admitted, are you the one that requests the advance directive, OSM #4 stated [name of admissions director - OSM #5]. An interview was conducted with OSM #5, the admissions director, on 4/13/2022 at 1:01 p.m. When asked if the advance directive is part of the admission paperwork, OSM #5 reviewed the admission paperwork and stated it was not part of the admission paperwork. Upon admission to you request a copy of the advance directive, OSM #5 stated she believed it was the social workers that do that.	F 578		

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F 578	Continued From page 14 On 04/13/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing and ASM # 4, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit 5. The facility staff failed to evidence documentation of a discussion regarding advanced directives for Resident # 61. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/04/2022, the resident scored 3 (three) out of 15 on the BIMS (brief interview for mental status), indicating the resident is severely impaired of cognition for making daily decisions. The comprehensive care plan for (R61) dated 04/23/2020 documented In part, "Focus: Resident has established Do not resuscitate (DNR) order. Date Initiated: 04/23/2020." Under "Interventions" it documented in part, "Educate resident and family on choices in regard to advance directives/code status. Date initiated: 04/23/2020." Review of (R61's) clinical record failed to evidence documentation of an advance directive. An interview was conducted on 4/13/2022 at 12:30 p.m. with OSM (other staff member) #3, the social services assistant. When asked who's responsibility it was for obtaining a copy of the advance directive and put it in the clinical record,	F 578		

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F 578	Continued From page 15 OSM #3 stated [name of social worker - OSM #4] keeps a log of what the resident's code status is. When asked what the advance directive is, OSM #3 stated it's a more detailed specific requests for end of life. When asked where it is documented that the resident have been offered to develop an advance directive, OSM #3 stated during the care plan meetings, the code status is reviewed. When asked the process for a new admission to determine if they have an advance directive, OSM #3 stated when the resident is admitted that is when we find out the code status and if they have an advance directive. When asked if there is no advance directive, do you offer to provide them information on how to develop an advance directive, OSM #3 stated only if the resident and or family request it, we don't offer the information to them to my knowledge. When asked when a resident is admitted and has an advance directive, where does it go, OSM #3 stated it is put into the record. When asked if she would document if the resident has or doesn't have an advance directive, OSM #3 stated if the resident has one it is scanned into the record. When asked on admission does the facility offer information on how to initiate an advance directive, OSM #3 stated, no only if they ask do we provide any information. OSM #3 reviewed the record for (R61). OSM #3 stated there was no advance directive on file. An interview was conducted on 4/13/2022 at 12:50 p.m. with OSM #4, the social worker. When asked the process for obtaining an advance directive for a new resident, OSM #4 stated on admission the facility asks for a copy of the advance directive and scan it into the chart. When asked if a resident does not have one, what do you do, do you offer information on	F 578		

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F 578	Continued From page 16	F 578		

developing an advance directive, OSM #4 stated if the resident and/or family is interested then we provide them the information. When asked if it is something you routinely do or do you wait for the resident and/or family to initiate, OSM #4 stated I don't initiate it. If they don't know how to develop an advance directive then we direct them. When asked should every resident have documentation of the discussion of advance directive, OSM #4 stated if it was discussed then it would be documented. A DDNR (durable do not resuscitate form was reviewed with OSM #4. OSM #4 stated that means they don't want CPR (cardiopulmonary resuscitation). When asked if that is an advance directive, OSM #4 stated no, an advance directive is much more information than that. OSM #4 stated the two are not the same. The residents were discussed that we did not see an advanced directive or evidence information was provided on advance directives, should that be done for all residents, OSM #4 stated, we could offer that. A social worker's note in the clinical record was reviewed. The note documented, the resident will remain DNR, when asked if that include the advance directive discussion, OSM #4 stated, no, it's only the code status. When a new resident is admitted, are you the one that requests the advance directive, OSM #4 stated [name of admissions director - OSM #5].

An interview was conducted with OSM #5, the admissions director, on 4/13/2022 at 1:01 p.m. When asked if the advance directive is part of the admission paperwork, OSM #5 reviewed the admission paperwork and stated it was not part of the admission paperwork. Upon admission to you request a copy of the advance directive, OSM #5 stated she believed it was the social workers that

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F 578	Continued From page 17 do that. On 04/13/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing and ASM # 4, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit 6. The facility staff failed to evidence documentation of a discussion regarding advanced directives for Resident # 58. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 02/15/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions. The comprehensive care plan for (R58) dated 02/19/2022 documented in part, "Focus: Resident is a full code. Date Initiated: 02/19/2022." Under "Interventions" it documented in part, "Initiate (CPR) Cardiopulmonary resuscitation as ordered. Date Initiated: 02/19/2022." Review of (R58's) clinical record failed to evidence documentation of an advance directive. An interview was conducted on 4/13/2022 at 12:30 p.m. with OSM (other staff member) #3, the social services assistant. When asked who's responsibility it was for obtaining a copy of the advance directive and put it in the clinical record, OSM #3 stated [name of social worker - OSM #4]	F 578		

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F 578	Continued From page 18 keeps a log of what the resident's code status is. When asked what the advance directive is, OSM #3 stated it's a more detailed specific requests for end of life. When asked where it is documented that the resident have been offered to develop an advance directive, OSM #3 stated during the care plan meetings, the code status is reviewed. When asked the process for a new admission to determine if they have an advance directive, OSM #3 stated when the resident is admitted that is when we find out the code status and if they have an advance directive. When asked if there is no advance directive, do you offer to provide them information on how to develop an advance directive, OSM #3 stated only if the resident and or family request it, we don't offer the information to them to my knowledge. When asked when a resident is admitted and has an advance directive, where does it go, OSM #3 stated it is put into the record. When asked if she would document if the resident has or doesn't have an advance directive, OSM #3 stated if the resident has one it is scanned into the record. When asked on admission does the facility offer information on how to initiate an advance directive, OSM #3 stated, no only if they ask do we provide any information. OSM #3 reviewed the record for (R58). OSM #3 stated there was no advance directive on file. An interview was conducted on 4/13/2022 at 12:50 p.m. with OSM #4, the social worker. When asked the process for obtaining an advance directive for a new resident, OSM #4 stated on admission the facility asks for a copy of the advance directive and scan it into the chart. When asked if a resident does not have one, what do you do, do you offer information on developing an advance directive, OSM #4 stated	F 578		

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F 578	Continued From page 19 if the resident and/or family is interested then we provide them the information. When asked if it is something you routinely do or do you wait for the resident and/or family to initiate, OSM #4 stated I don't initiate it. If they don't know how to develop an advance directive then we direct them. When asked should every resident have documentation of the discussion of advance directive, OSM #4 stated if it was discussed then it would be documented. A DDNR (durable do not resuscitate form was reviewed with OSM #4. OSM #4 stated that means they don't want CPR (cardiopulmonary resuscitation). When asked if that is an advance directive, OSM #4 stated no, an advance directive is much more information than that. OSM #4 stated the two are not the same. The residents were discussed that we did not see an advanced directive or evidence information was provided on advance directives, should that be done for all residents, OSM #4 stated, we could offer that. A social worker's note in the clinical record was reviewed. The note documented, the resident will remain DNR, when asked if that include the advance directive discussion, OSM #4 stated, no, it's only the code status. When a new resident is admitted, are you the one that requests the advance directive, OSM #4 stated [name of admissions director - OSM #5]. An interview was conducted with OSM #5, the admissions director, on 4/13/2022 at 1:01 p.m. When asked if the advance directive is part of the admission paperwork, OSM #5 reviewed the admission paperwork and stated it was not part of the admission paperwork. Upon admission to you request a copy of the advance directive, OSM #5 stated she believed it was the social workers that do that.	F 578		

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F 578	Continued From page 20 On 04/13/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing and ASM # 4, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit.	F 578	**F582 – Medicaid/Medicare Coverage/Liability Notice** 1.) Resident #106 is not currently a resident of Evergreen Health and Rehab, therefore it is not appropriate to provide an ABN at this time. Evergreen Health and Rehab has identified that Medicare A residents are at risk from not receiving a SNFABN letter. 2.) Administrator/designee audited all skilled discharges since 4/1/22 to ensure that the SNFABN was issued appropriately. No other concerns were identified. 3.) The Administrator/designee has in-serviced Director of Therapy Department and Social Services Director regarding SNFABN policy and procedure. The in-service includes, but not limited to, the facility to provide SNFABN "information to the beneficiary so that s/he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility".	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide	F 582		

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F 582	Continued From page 21 notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide skilled nursing facility advance beneficiary notice of non-coverage (SNFABN) to one of three beneficiary protection notification resident reviews, Resident #106. Resident #106's (R106) last covered day of Medicare part A services was 11/7/21. The facility staff failed to provide the SNFABN to Resident #106 (and/or the resident's representative). The findings include:	F 582	4.) The Administrator/designee will meet with therapy department manager and social services director weekly for 6 weeks to review all previous weeks SNF discharges from therapy services to ensure SNFABN was issued prior to discharge of services and documentation of such is completed appropriately. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be taken. The Administrator/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 582	Continued From page 22 R106 was admitted to the facility on 10/8/21 with diagnoses that included but were not limited to cellulitis. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/17/22, the resident scored 13 out of 15 on the BIMS (brief interview for mental status), indicating the resident is not impaired for making daily decisions. A review of a list of residents who were discharged from Medicare Part A skilled services within the last six months revealed R106 was discharged from skilled services on 11/7/21. On 4/13/22 at 1:30 p.m., an interview was conducted with RN (registered nurse) #3. RN #3 stated a SNFABN should be issued to a resident or representative within two days before the resident is discharged from skilled services. RN #3 stated he could not imagine R106 was not provided a SNFABN but he could not find evidence to show R106 (or the representative) was provided a SNFABN. RN #3 stated he delivers the SNFABNs then gives them to the medical records department to scan into the chart but that never happened for R106. On 4/13/22 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Medicare Liability Notice" documented, "The facility will provide written notice to residents receiving Medicare Part A services under the Fee-for-Service Medicare program when the nursing facility identifies that Medicare will no longer pay for covered skilled services. These notices will provide the resident	F 582		

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F 582	Continued From page 23 with the opportunity to decide if they wish to continue receiving the skilled that may not be paid for by Medicare and assume financial responsibility for the care and of their right to appeal the decision of non-coverage." No further information was presented prior to exit.	F 582	**F622/12VAC 5-371-140/12VAC 5-371-150/12VAC 5-371-150-** **Transfer and Discharge Requirements** ..) Residents #94 and #59 and #10 returned from the emergency room or hospital and therefore no corrective action can be taken with the residents at this time. Residents #124 and #95 are no longer residents of this facility and therefore no corrective action can be taken at this time. It is the policy of Evergreen Health and Rehab to ensure that transfer and discharge requirements are met. All residents have the potential to be affected by the alleged deficient practice. 2.) Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility have been reviewed to ensure that the required information was sent with the resident. Any variances have been corrected.	
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(II)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid;	F 622		

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EVERGREEN HEALTH AND REHAB	360 MILLWOOD AVENUE WINCHESTER, VA 22601

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 24 or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of	F 622	3.) The Director of Nursing/designee has educated clinical nursing staff, including RN's and LPN's, on documents required to be sent with resident upon transfer and discharge. The education included, but was not limited to: sending contact information of the practitioner responsible for the care of the resident, resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals; goals with the resident upon discharge or	

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F 622	Continued From page 25 this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to provide evidence that all required information was provided to the hospital staff when five out of 45 residents in the survey sample were transferred to the hospital; Residents #94, #59, #124, #95 and #10. The findings include: 1. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #94 was transferred to the hospital on 2/16/22. Per the facility's "Transfer Check List" which includes the following documents: eINTERACT (interventions to reduce acute care transfers) V5 care form, face sheet, DNR (do not resuscitate)/advanced directives, notice of transfer or discharge form, bed hold form, recent	F 622	transfer and documentation on the medical record that the information was provided to the resident upon transfer or discharge to the hospital. 4) The Director of Nursing/designee will review all emergency room and hospital transfers for six weeks to ensure the comprehensive care plan summary and goals was sent with the resident and documented in the medical record. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5) Date of Compliance: 5/16/2022	

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F 622	Continued From page 26	F 622		

history, MAR/TAR (medication administration record/treatment administration record), care plan, immunization report, pertinent labs, pertinent tests/diagnostics, provider progress notes/assessments and belongings. No evidence of these documents being provided was revealed.

Resident #94 was admitted to the facility on 6/17/21 with diagnosis included but were not limited to: metabolic encephalopathy, chronic obstructive pulmonary disease and duodenal ulcer.

Resident #94's most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/14/22, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, personal hygiene/bathing and supervision in eating/ locomotion.

A review of the nursing progress note dated 2/16/22 at 4:59 PM, revealed the following, "Patient with increased confusion, jaundice in color and black tarry stool noted. Nurse Practitioner notified and order to send to the emergency room for evaluation."

On 4/12/22 at approximately 2:45 PM a request was made for the evidence of required information was provided to the hospital on 2/16/22 for Resident #94.

On 4/12/22 at 4:53 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, stated, we do not have any

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F 622	Continued From page 27 evidence of any of this information for this resident. We only have a progress note on Resident #94 for 2/16/22 that we notified the next of kin. We realize that this is something we need to fix. On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated we send a profile sheet with the resident's demographics and insurance information with residents for hospital transfers. LPN #4 stated we also send any DNR (do not resuscitate), the medication list, physician orders and the completed eINTERACT transfer form from the computer. When asked if there is a copy of what is sent with the resident to the hospital, LPN #4 stated No, I do not think so. An interview was conducted on 4/13/22 at 2:37 PM with ASM #2, the director of nursing. When asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Facility Initiated	F 622		

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F 622	Continued From page 28 Transfer and Discharge" policy with no date, which reveals, "The transfer or discharge is necessary for the resident's welfare and the resident's need cannot be met in the facility. The medical record will contain documentation that the needed services are available at the receiving facility or location." No further information was provided prior to exit. 2. The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #59 was transferred to the hospital on 2/4/22. Per the facility's "Transfer Check List" which includes the following documents: eINTERACT (interventions to reduce acute care transfers) V5 care form, face sheet, DNR (do not resuscitate)/advanced directives, notice of transfer or discharge form, bed hold form, recent history, MAR/TAR (medication administration record/treatment administration record), care plan, immunization report, pertinent labs, pertinent tests/diagnostics, provider progress notes/assessments and belongings. No evidence of these documents being provided was revealed. Resident #59 was admitted to the facility on 5/2/18 with diagnosis included but were not limited to: congestive heart failure, diabetes mellitus, encephalopathy, chronic obstructive pulmonary disease and atrial fibrillation. Resident #59's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/26/22, coded the resident as scoring 06 out of 15 on the BIMS	F 622		

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F 622	Continued From page 29 (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as requiring supervision in bed mobility, transfers, locomotion, dressing, eating and limited assistance for personal hygiene/bathing. A review of the nurse practitioner progress note dated 2/4/22 at 8:37 AM, which revealed, "Overnight nurse reports that resident is not acting herself this morning. Stroke like symptoms. 911 called for transport." On 4/12/22 at approximately 2:45 PM a request was made for the evidence of required information was provided to the hospital on 2/4/22 for Resident #59. On 4/12/22 at 4:53 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, stated, we do not have any evidence of any of this information for this resident. We only have a progress note on Resident #59 for 2/4/22 of the episode. We realize that this is something we need to fix. On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated we send a profile sheet with the resident's demographics and insurance information with residents for hospital transfers. LPN #4 stated we also send any DNR (do not resuscitate), the medication list, physician orders and the completed eINTERACT transfer form from the computer. When asked if there is a copy of what is sent with the resident to the hospital, LPN #4 stated No, I do not think so. An interview was conducted on 4/13/22 at 2:37	F 622		

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F 622	Continued From page 30 PM with ASM #2, the director of nursing. When asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Facility Initiated Transfer and Discharge" policy with no date, which reveals, "The transfer or discharge is necessary for the resident's welfare and the resident's need cannot be met in the facility. The medical record will contain documentation that the needed services are available at the receiving facility or location." No further information was provided prior to exit. 3. During the closed record review it was revealed the facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #124 was transferred to the hospital on 1/20/22.] Per the facility's "Transfer Check List" which	F 622		

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F 622	Continued From page 31 includes the following documents: eINTERACT (interventions to reduce acute care transfers) V5 care form, face sheet, DNR (do not resuscitate)/advanced directives, notice of transfer or discharge form, bed hold form, recent history, MAR/TAR (medication administration record/treatment administration record), care plan, immunization report, pertinent labs, pertinent tests/diagnostics, provider progress notes/assessments and belongings. No evidence of these documents being provided was revealed. Resident #124 was admitted to the facility on 1/5/22 with diagnosis included but were not limited to: congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease and acute respiratory failure. Resident #124's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 2/21/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, personal hygiene/bathing and independent for eating. A review of the nursing progress note dated 1/20/22 at 9:46 AM, revealed the following, "Resident awake but unresponsive at med pass. 911 called and paramedics dispatched and arrived at 0946. Resident's son notified at 0945." On 4/13/22 at approximately 12:30 PM a request was made for the evidence of required information was provided to the hospital on 1/20/22 for Resident #124.	F 622		

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F 622	Continued From page 32 On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated we send a profile sheet with the resident's demographics and insurance information with residents for hospital transfers. LPN #4 stated we also send any DNR (do not resuscitate), the medication list, physician orders and the completed eINTERACT transfer form from the computer. When asked if there is a copy of what is sent with the resident to the hospital, LPN #4 stated No, I do not think so. An interview was conducted on 4/13/22 at 2:37 PM with ASM #2, the director of nursing. When asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. On 4/13/22 at 5:13 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, stated, we do not have any evidence of any of this information for this resident. We only have a progress note on Resident #124 for 1/20/22 episode. We realize	F 622		

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F 622	Continued From page 33 that this is something we need to fix. According to the facility's "Facility Initiated Transfer and Discharge" policy with no date, which reveals, "The transfer or discharge is necessary for the resident's welfare and the resident's need cannot be met in the facility. The medical record will contain documentation that the needed services are available at the receiving facility or location." No further information was provided prior to exit. 4. The facility staff failed to evidence providing the receiving facility the contact information of the practitioner responsible for the care of the resident and the comprehensive care plan goals for a facility initiated transfer of Resident #95 (R95) on 3/1/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/14/2022, the resident was assessed as being severely impaired for making daily decisions. The progress notes for R95 documented in part, - "3/1/2022 16:43 (4:43 p.m.) Nursing note. Note Text: This nurse was given the information that the resident had pulled out her gtube (gastrostomy tube). MPOA (medical power of attorney) was notified of gtube being pulled out and that resident would need to be sent to	F 622		

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F 622	Continued From page 34 hospital for replacement. MPOA (Son) ask this nurse "Why isn't mom eating anything?" This nurse informed MPOA that it would be up to how well she was progressing and what the Modified Barium Swallow study showed. Resident with no signs or symptoms of distress noted at time of transfer. EMS (emergency medical services) arrived for transport with resident requiring total assist from staff members and EMS crew for transfer from bed to gurney. VSS (vital signs stable). No signs or symptoms of pain or discomfort noted. Report called to ED (emergency department)." The eInteract Transfer form for R95 dated 3/1/2022 16:14 (4:14 p.m.) documented in part, code status, responsible party contact information and reason for transfer. Review of the clinical record for R95 failed to evidence documentation of the information provided to the receiving facility or evidence of the contact information of the practitioner responsible for the care of the resident and the comprehensive care plan goals for the facility initiated transfer on 3/1/2022. On 4/13/2022 at 10:12 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator for evidence of the required transfer documentation provided to the receiving facility for the facility-initiated transfer on 3/1/2022 for R95. On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. LPN #4 stated that they sent a profile sheet with the residents demographics and insurance information with residents for hospital transfers.	F 622		

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F 622	Continued From page 35 LPN #4 stated that they also sent any DNR (do not resuscitate), the medication list, physician orders and the completed eInteract transfer form from the computer. On 4/13/2022 at 2:37 p.m., ASM #2, the director of nursing, stated that they had a mock survey 3/24/22-3/26/22 and were revising their process based on that. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated that the new company had one and they had been inservicing the staff on using it but they needed to do more work on this process. On 4/13/2022 at 4:53 p.m., ASM #1, and ASM #2 stated that they did not have any evidence of the documents sent to the hospital on 3/1/2022 for R95. ASM #2 stated that they only had the progress note and that they realized that this was something that they needed to fix. On 4/13/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit. 5. The facility staff failed to evidence required documentation was provided for Resident # 10 to the receiving facility for a facility-initiated transfer on 12/31/2021. On the most recent MDS (minimum data set), a	F 622		

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quarterly assessment with an ARD (assessment reference date) of 03/31/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions.

The facility's nurse practitioner's note dated 12/31/2022 documented in part, "Received phone call early this am (a.m.) around 330 am 3:30 a.m.), that pt (patient) was having visual hallucinations, gave verbal order to send to e.r. (emergency room) see previous notes, this is not a surprise and expected a decline soon with pt since not taking in much fluids or not eating well. she [sic] continues to tell me she is. emt (Emergency medical technicians) arrived and refused to take her to e.r since she refused to go. she answered their questions appropriately even tho [sic] she is still seeing ppl [sic] (people) that is not present and lab (laboratory) confirmed critical co2 (carbon dioxide) levels. i [sic] immediately came to work around 530 am and spoke with this pt about what is going on, she continues to tell me there is 4 ppl standing around me. she wants to take a nap now and thanked me for coming in to see her. REFUSED E.R AGAIN."

Review of the clinical record failed to evidence documentation of information provided to the hospital on 12/31/2021 for Resident # 10.

On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. LPN # 4 stated that they sent a profile sheet with the resident's demographics and insurance information with residents for hospital transfers. LPN # 4 stated that they also sent any DNR (do not resuscitate), the medication list, physician orders and the completed Interact transfer form

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 37 from the computer. On 04/13/2022 at 2:37 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about the process for send documentation to the receiving facility for a facility initiated transfer ASM # 2 stated that based on mock survey on 03/24/2022 through 03/26/2022, they are revising their entire process. ASM # 2 stated that with the leaving of the previous administrator, who used to do some of the process, they found they had holes in the process and are completely revamping bed hold, written notice to ombudsman. When asked about the written responsible party notification, ASM #2 stated, they found in the mock survey, that process needed revamping also. ASM # 2 further stated that right now the progress note in the chart is the only written evidence they have of the responsible party notification. On 04/13/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing and ASM # 4, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495142	A. BUILDING _____ B. WING _____	C 04/14/2022

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F 623	Continued From page 38 language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F 623	**F623- Notice Requirements Before Transfer/Discharge** 1.) Residents #94 and #59 and #10 returned from the emergency room or hospital and therefore no corrective action can be taken with the residents at this time. Residents #124 and #95 are no longer residents of this facility and therefore no corrective action can be taken at this time. It is the policy of Evergreen Health and Rehab to ensure that notice requirements before transfer/discharge are met. All residents have the potential to be affected by the alleged deficient practice. 2.) Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility have been reviewed to ensure that evidence of written notification of transfer was provided to the responsible party and/or the ombudsman. Any variances have been corrected.	

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F 623	Continued From page 39 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623	3.) The Administrator/designee has educated social workers on notice requirements before transfer/discharge. The education included, but was not limited to, notifying the resident or resident representative and the ombudsman of transfer/discharge, and documentation in the medical record that the information was provided to the resident upon transfer or discharge. 4.) The Administrator/designee will review transfers/discharges for six weeks to ensure that notification of transfer/discharge was sent to the resident or resident representative and ombudsman, and that the notification was documented in the medical record. The Administrator/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 623	Continued From page 40 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence written documentation to the Resident or RP (responsible party) and ombudsman upon transfer to the hospital for five out of 45 residents in the survey sample; Residents #94, #59, #124, #95 and #10. The findings include: 1. The facility staff failed notify the RP and the ombudsman when Resident #94 was transferred to the hospital on 2/16/22. Resident #94 was admitted to the facility on 6/17/21 with diagnosis included but were not limited to: metabolic encephalopathy, chronic obstructive pulmonary disease and duodenal ulcer. Resident #94's most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/14/22, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as	F 623		

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F 623	Continued From page 41 requiring extensive assistance in bed mobility, transfers, dressing, personal hygiene/bathing and supervision in eating/ locomotion. A review of the nursing progress note dated 2/16/22 at 4:59 PM, revealed the following, "Patient with increased confusion, jaundice in color and black tarry stool noted. Nurse Practitioner notified and order to send to the emergency room for evaluation." On 4/12/22 at approximately 2:45 PM a request was made for the evidence of written documentation to the Resident or RP (responsible party) and ombudsman was provided for the 2/16/22 hospital transfer for Resident #94. On 4/12/22 at 4:53 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, stated, we do not have any evidence of any of this information for this resident. We only have a progress note on Resident #94 for 2/16/22 that we notified the next of kin. We realize that this is something we need to fix. On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked what notification is provided to the RP, LPN #4 stated we make a call to the RP and document it in the progress notes. When asked if there is written notification sent to the RP, LPN #4 stated, we do not send written notice. When asked who notifies the ombudsman, LPN #4 stated, that is not nursing, I am not sure who does it. On 4/13/22 at 1:28 PM, an interview was	F 623		

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F 623	Continued From page 42 conducted with OSM (other staff member) #3, the social services assistant. When asked what written notification is provided to the RP and the ombudsman, OSM #3 stated, nursing verbally notifies the RP, there is not anything in writing. Should there be anything in writing. I think the previous administrator used to notify the ombudsman, but I am not sure. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Facility Initiated Transfer and Discharge" policy with no date, which reveals, "Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Notice must be made as soon as practicable before transfer or discharge when the health of the individual would be endangered. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman." No further information was provided prior to exit. 2. The facility staff failed notify the RP and the ombudsman when Resident #59 was transferred to the hospital on 2/4/22. Resident #59 was admitted to the facility on 5/2/18 with diagnosis included but were not limited to: congestive heart failure, diabetes mellitus, encephalopathy, chronic obstructive	F 623		

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F 623	Continued From page 43 pulmonary disease and atrial fibrillation. Resident #59's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/26/22, coded the resident as scoring 06 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as requiring supervision in bed mobility, transfers, locomotion, dressing, eating and limited assistance for personal hygiene/bathing. A review of the nurse practitioner progress note dated 2/4/22 at 8:37 AM, which revealed, "Overnight nurse reports that resident is not acting herself this morning. Stroke like symptoms. 911 called for transport." On 4/12/22 at approximately 2:45 PM a request was made for the evidence of written documentation to the Resident or RP (responsible party) and ombudsman was provided for the hospital transfer for Resident #59 on 2/4/22. On 4/12/22 at 4:53 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, stated, we do not have any evidence of any of this information for this resident. We only have a progress note on Resident #59 for 2/4/22 of the episode. We realize that this is something we need to fix. On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked what notification is provided to the RP, LPN #4 stated we make a call to the RP and document it in the progress notes. When asked if	F 623		

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F 623	Continued From page 44 there is written notification sent to the RP, LPN #4 stated, we do not send written notice. When asked who notifies the ombudsman, LPN #4 stated, that is not nursing, I am not sure who does it. On 4/13/22 at 1:28 PM, an interview was conducted with OSM (other staff member) #3, the social services assistant. When asked what written notification is provided to the RP and the ombudsman, OSM #3 stated, nursing verbally notifies the RP, there is not anything in writing. Should there be anything in writing. I think the previous administrator used to notify the ombudsman, but I am not sure. An interview was conducted on 4/13/22 at 2:37 PM with ASM #2, the director of nursing. When asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Facility Initiated Transfer and Discharge" policy with no date, which reveals, "Before a facility transfers or	F 623		

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F 623	Continued From page 45 discharges a resident, the facility will notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Notice must be made as soon as practicable before transfer or discharge when the health of the individual would be endangered. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman." No further information was provided prior to exit. 3. The facility staff failed notify the RP and the ombudsman when Resident #124 was transferred to the hospital on 1/20/22. Resident #124 was admitted to the facility on 1/5/22 with diagnosis included but were not limited to: congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease and acute respiratory failure. Resident #124's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 2/21/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, personal hygiene/bathing and independent for eating. A review of the nursing progress note dated 1/20/22 at 9:46 AM, revealed the following, "Resident awake but unresponsive at med pass.	F 623		

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F 623	Continued From page 46 911 called and paramedics dispatched and arrived at 0946. Resident's son notified at 0945." On 4/13/22 at approximately 12:30 PM a request was made for the evidence of written documentation to the Resident or RP (responsible party) and ombudsman was provided for the hospital transfer for Resident #124 on 1/20/22. On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked what notification is provided to the RP, LPN #4 stated we make a call to the RP and document it in the progress notes. When asked if there is written notification sent to the RP, LPN #4 stated, we do not send written notice. When asked who notifies the ombudsman, LPN #4 stated, that is not nursing, I am not sure who does it. On 4/13/22 at 1:28 PM, an interview was conducted with OSM (other staff member) #3, the social services assistant. When asked what written notification is provided to the RP and the ombudsman, OSM #3 stated, nursing verbally notifies the RP, there is not anything in writing. Should there be anything in writing. I think the previous administrator used to notify the ombudsman, but I am not sure. An interview was conducted on 4/13/22 at 2:37 PM with ASM #2, the director of nursing. When asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the	F 623		

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F 623	Continued From page 47 process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. On 4/13/22 at 5:13 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, stated, we do not have any evidence of any of this information for this resident. We only have a progress note on Resident #124 for 1/20/22 episode. We realize that this is something we need to fix. According to the facility's "Facility Initiated Transfer and Discharge" policy with no date, which reveals, "Before a facility transfers or discharges a resident, the facility will notify the resident and the resident's representative of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. Notice must be made as soon as practicable before transfer or discharge when the health of the individual would be endangered. The facility will send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman." No further information was provided prior to exit.	F 623		

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F 623	Continued From page 48 4. The facility staff failed to evidence written notification to the responsible party for a facility initiated transfer of Resident #95 (R95) on 3/1/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/14/2022, the resident was assessed as being severely impaired for making daily decisions. The progress notes for R95 documented in part, - "3/1/2022 16:43 (4:43 p.m.) Nursing note. Note Text: This nurse was given the information that the resident had pulled out her gtube (gastrostomy tube). MPOA (medical power of attorney) was notified of gtube being pulled out and that resident would need to be sent to hospital for replacement. MPOA (Son) ask this nurse "Why isn't mom eating anything?" This nurse informed MPOA that it would be up to how well she was progressing and what the Modified Barium Swallow study showed. Resident with no signs or symptoms of distress noted at time of transfer. EMS (emergency medical services) arrived for transport with resident requiring total assist from staff members and EMS crew for transfer from bed to gurney. VSS (vital signs stable). No signs or symptoms of pain or discomfort noted. Report called to ED (emergency department)." Review of the clinical record for R95 failed to evidence documentation of written notification to the responsible party for the facility initiated transfer on 3/1/2022. On 4/13/2022 at 10:12 a.m., a request was made via written list to ASM (administrative staff	F 623		

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F 623	Continued From page 49	F 623		

member) #1, the administrator for evidence of written notification to the responsible party for the facility-initiated transfer on 3/1/2022 for R95.

On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. LPN #4 stated that they did not send any written notification of transfer to the responsible party.

On 4/13/2022 at 1:28 p.m., an interview was conducted with OSM (other staff member) #3, social services assistant, discharge planner. OSM #3 stated that they did not provide a written notice of transfer to residents/responsible parties at the current time, that there was only a verbal notification done when a resident was sent out to the hospital.

On 4/13/2022 at 2:37 p.m., an interview was conducted with ASM #2. ASM #2 stated that they had a mock survey 3/24/22-3/26/22 and were revising their process based on that. When asked about the written notice to the responsible party, ASM #2 stated that they had found that the process needed to be revamped. ASM #2 stated that right now the progress note in the chart was the only evidence they had of notification of the responsible party.

On 4/13/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the findings.

No further information was provided prior to exit.

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	495142	A. BUILDING _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVERGREEN HEALTH AND REHAB	380 MILLWOOD AVENUE WINCHESTER, VA 22601

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F 623	Continued From page 50	F 623		

5. The facility staff failed to evidence written notification was provided for Resident # 10 and the ombudsman for a facility-initiated transfer on 12/31/2021.

On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/31/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status), indicating the resident is cognitively intact for making daily decisions.

The facility's nurse practitioner's note dated 12/31/2022 documented in part, "Received phone call early this am (a.m.) around 330 am 3:30 a.m.), that pt (patient) was having visual hallucinations, gave verbal order to send to e.r. (emergency room) see previous notes, this is not a surprise and expected a decline soon with pt since not taking in much fluids or not eating well. she [sic] continues to tell me she is. emt (Emergency medical technicians) arrived and refused to take her to e.r since she refused to go. she answered their questions appropriately even tho [sic] she is still seeing ppl [sic] (people) that is not present and lab (laboratory) confirmed critical co2 (carbon dioxide) levels. i [sic] immediately came to work around 530 am and spoke with this pt about what is going on, she continues to tell me there is 4 ppl standing around me. she wants to take a nap now and thanked me for coming in to see her. REFUSED E.R AGAIN."

The facility's "Progress Note" dated 12/31/2021 documented, "Iv (intravenous - within the vein) unsuccessful, when iv pulled this nursed asked resident if we could send her to get checked out

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F 623	Continued From page 51 at the hospital and resident agreed. 911 was called for transport. [Name of Nurse Practitioner] was notified of transfer and [Name of (R10's) Friend] was notified as well. Review of the clinical record failed to evidence documentation of written notification was provided to (R10) and the ombudsman for the facility initiated transfer on 12/31/2021. On 04/13/2022 at 2:37 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about the process for send documentation to the receiving facility for a facility initiated transfer ASM # 2 stated that based on mock survey on 03/24/2022 through 03/26/2022, they are revising their entire process. ASM # 2 stated that with the leaving of the previous administrator, who used to do some of the process, they found they had holes in the process and are completely revamping bed hold, written notice to ombudsman. On 04/13/2022 at approximately 5:00 p.m., ASM (administrative staff member) # 1, administrator, and ASM # 2, director of nursing and ASM # 4, regional nurse consultant, were made aware of the above findings. No further information was provided prior to exit	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a	F 625		

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F 625	Continued From page 52 nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (I) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (II) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined the facility staff failed to evidence a bed hold was provided to four out of 45 residents in the survey sample who were transferred to the hospital; Residents #94, #59, #124 and #95. The findings include: 1. The facility staff failed to provide evidence that bed hold information provided to Resident #94 when Resident #94 was transferred to the	F 625	**F625- Notice of Bed Hold Policy Before/Upon Transfer** . 1.) Residents #94 and #59 returned from the emergency room or hospital and therefore no corrective action can be taken with the residents at this time. Residents #124 and #95 are no longer residents of this facility and therefore no corrective action can be taken at this time. It is the policy of Evergreen Health and Rehab to ensure that bed hold policy requirements are met. All residents have the potential to be affected by the alleged deficient practice. 2.) Residents that transferred to the emergency room or admitted to the hospital in the last 30 days and remain outside of this facility have been reviewed to ensure that bed hold notice was provided to the resident and/or the responsible party for each facility-initiated transfer. Any variances have been corrected.	

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F 625	Continued From page 53 hospital on 2/16/22. Resident #94 was admitted to the facility on 6/17/21 with diagnosis included but were not limited to: metabolic encephalopathy, chronic obstructive pulmonary disease and duodenal ulcer. Resident #94's most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 3/14/22, coded the resident as scoring 03 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, personal hygiene/bathing and supervision in eating/ locomotion. A review of the nursing progress note dated 2/16/22 at 4:59 PM, revealed the following, "Patient with increased confusion, jaundice in color and black tarry stool noted. Nurse Practitioner notified and order to send to the emergency room for evaluation." On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked who provides the bed hold, LPN #4 stated it is not nursing. On 4/13/22 at 1:28 PM, an interview was conducted with OSM (other staff member) #3, the social services assistant. When asked who provides the bed hold, OSM #3 stated, nursing provides the bed hold. An interview was conducted on 4/13/22 at 2:37 PM with ASM #2, the director of nursing. When	F 625	3.) The Director of Nursing/designee has educated clinical nursing staff, including RNs and LPNs on providing the bed hold policy to residents and/or resident representatives upon each facility-initiated transfer. The education included, but was not limited to, providing the bed hold policy to residents and/or resident representatives upon facility-initiated transfer, and documentation in the medical record that the information was provided. 4.) The Director of Nursing/designee will review all facility-initiated transfers for six weeks to ensure that the bed hold policy was provided to the resident or resident representative and that the this was documented in the medical record. The Director of Nursing/designee will identify	

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F 625	Continued From page 54 asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 2:45 PM, ASM #2 stated, Admissions is to fill out the bed hold policy. We do not have evidence of the bed hold for this resident. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Bed Hold" policy with no date, which reveals, "Prior to initiated transfers, resident or resident representatives will be informed in writing of the bed hold and return policy. Residents and representatives will be provided information on the facility's bed hold policy at the time of admission. A second written notice will be provided to the resident, and if applicable the resident's representative, at the time of transfer or in the case of emergency within 24 hours." No further information was provided prior to exit.	F 625	any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 625	Continued From page 55 2. The facility staff failed to provide evidence that bed hold information provided to Resident #59 when Resident #59 was transferred to the hospital on 2/4/22. Resident #59 was admitted to the facility on 5/2/18 with diagnosis included but were not limited to: congestive heart failure, diabetes mellitus, encephalopathy, chronic obstructive pulmonary disease and atrial fibrillation. Resident #59's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/26/22, coded the resident as scoring 06 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. The resident was coded as requiring supervision in bed mobility, transfers, locomotion, dressing, eating and limited assistance for personal hygiene/bathing. A review of the nurse practitioner progress note dated 2/4/22 at 8:37 AM, which revealed, "Overnight nurse reports that resident is not acting herself this morning. Stroke like symptoms. 911 called for transport." On 4/12/22 at approximately 2:45 PM a request was made for the evidence of required bed hold information for Resident #59. On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked who provides the bed hold, LPN #4 stated it is not nursing. On 4/13/22 at 1:28 PM, an interview was conducted with OSM (other staff member) #3, the	F 625		

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F 625	Continued From page 56 social services assistant. When asked who provides the bed hold, OSM #3 stated, nursing provides the bed hold. An interview was conducted on 4/13/22 at 2:37 PM with ASM #2, the director of nursing. When asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 2:45 PM, ASM #2 stated, Admissions is to fill out the bed hold policy. We do not have evidence of the bed hold for this resident. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Bed Hold" policy with no date, which reveals, "Prior to initiated transfers, resident or resident representatives will be informed in writing of the bed hold and return policy. Residents and representatives will be provided information on the facility's bed hold policy at the time of admission. A second written notice will be provided to the resident, and if applicable the resident's representative, at the time of transfer or in the case of emergency	F 625		

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F 625	Continued From page 57 within 24 hours." No further information was provided prior to exit. 3. The facility staff failed to provide evidence that bed hold information provided to Resident # 124 when Resident #124 was transferred to the hospital on 1/20/22. Resident #124 was admitted to the facility on 1/5/22 with diagnosis included but were not limited to: congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease and acute respiratory failure. Resident #124's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 2/21/22, coded the resident as scoring 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, personal hygiene/bathing and independent for eating. A review of the nursing progress note dated 1/20/22 at 9:46 AM, revealed the following, "Resident awake but unresponsive at med pass. 911 called and paramedics dispatched and arrived at 0946. Resident's son notified at 0945." On 4/13/2022 at 12:40 PM, an interview was conducted with LPN (licensed practical nurse) #4. When asked who provides the bed hold, LPN #4 stated it is not nursing.	F 625		

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F 625	Continued From page 58 On 4/13/22 at 1:28 PM, an interview was conducted with OSM (other staff member) #3, the social services assistant. When asked who provides the bed hold, OSM #3 stated, nursing provides the bed hold. An interview was conducted on 4/13/22 at 2:37 PM with ASM #2, the director of nursing. When asked the process for sending documentation to the hospital for resident transfers, ASM #2 stated, based on our mock survey 3/24/22-3/26/22, we are revising our entire process regarding resident to hospital transfers. When our old administrator left, we found she used to do some of the process, and we found we had holes in the process. When asked if there was a transfer checklist for residents to the hospital, ASM #2 stated, Yes, the company has one and we have been in servicing the staff on using this form but we need to do more work on this. On 4/13/22 at 2:45 PM, ASM #2 stated, Admissions is to fill out the bed hold policy. We do not have evidence of the bed hold for this resident. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Bed Hold" policy with no date, which reveals, "Prior to initiated transfers, resident or resident representatives will be informed in writing of the bed hold and return policy. Residents and representatives will be provided information on the facility's bed hold policy at the time of admission. A second written notice will be provided to the resident, and if	F 625		

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F 625	Continued From page 59 applicable the resident's representative, at the time of transfer or in the case of emergency within 24 hours." No further information was provided prior to exit. 4. The facility staff failed to evidence bed hold notice provided to the resident/responsible party for a facility initiated transfer of Resident #95 (R95) on 3/1/2022. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 2/14/2022, the resident was assessed as being severely impaired for making daily decisions. The progress notes for R95 documented in part, - "3/1/2022 16:43 (4:43 p.m.) Nursing note. Note Text: This nurse was given the information that the resident had pulled out her gtube (gastrostomy tube). MPOA (medical power of attorney) was notified of gtube being pulled out and that resident would need to be sent to hospital for replacement. MPOA (Son) ask this nurse "Why isn't mom eating anything?" This nurse informed MPOA that it would be up to how well she was progressing and what the Modified Barium Swallow study showed. Resident with no signs or symptoms of distress noted at time of transfer. EMS (emergency medical services) arrived for transport with resident requiring total assist from staff members and EMS crew for transfer from bed to gurney. VSS (vital signs stable). No signs or symptoms of pain or discomfort noted. Report called to ED (emergency department)."	F 625		

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F 625	Continued From page 60 Review of the clinical record failed to evidence documentation of bed hold notice provided to the resident/responsible party for the facility initiated transfer on 3/1/2022 for R95. On 4/13/2022 at 10:12 a.m., a request was made via written list to ASM (administrative staff member) #1, the administrator for evidence of bed hold notice provided to the resident/responsible party for the facility-initiated transfer on 3/1/2022 for R95. On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) # 4. LPN #4 stated that they did not provide a bed hold notice but they called the responsible party the next day if the resident was admitted to inform them of the price for a bed hold to see if they wanted to hold the bed. On 4/13/2022 at 2:37 p.m., ASM #2, stated that they had a mock survey 3/24/22-3/26/22 and were revising their process based on that. ASM #2 stated that the previous administrator used to do some of the process they found that there were holes in the process. ASM #2 stated that they were revamping the bed hold process. On 4/13/2022 at 2:45 p.m., ASM #2 stated that previously admissions would fill out the bed hold policy and the administrator would then notify the responsible party and the ombudsman. On 4/13/2022 at 4:53 p.m., ASM #1, and ASM #2 stated that they did not have any evidence of the bed hold notice. ASM #2 stated that they realized that this was something that they needed to fix. On 4/13/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of	F 625		

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F 625	Continued From page 61 nursing and ASM #4, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit.	F 625	**F641/12 VAC 5-371-250 (A)(12)- Accuracy of Assessments** 1.) The complete MDS was reviewed for residents #31 and #110. BIMS and Section C were completed for both residents to ensure that the MDS accurately reflects the resident's status and that the MDS was properly completed. Evergreen Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee has performed an MDS audit of BIMS and Section C for residents with a completed MDS assessment for the 30 days to ensure that the MDS accurately reflects the resident's status and was properly completed. Any variances have been addressed and the MDS has been updated. 3.) The Director of Nursing/designee has in-serviced MDS staff regarding accurate and timely MDS completion. The in-service includes, but no limited to, the importance of completing the BIMS and Section C and the importance of the MDS accurately reflecting the resident's status.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete MDS (minimum data set) for 2 of 45 residents in the survey sample, Resident #31 and Resident #110. The findings include: 1. The facility staff failed to complete the BIMS (brief interview for mental status) assessment for Resident #31's (R31) quarterly MDS assessment with an ARD (assessment reference date) of 1/24/2022. Section B of R31's quarterly MDS assessment with an ARD of 1/24/2022 coded the resident as being understood. Section C0100 documented the BIMS assessment should be conducted. All of the questions related to the BIMS assessment (C0200 through C0400) and the BIMS summary score were coded as not assessed. On 4/13/2022 at 1:07 p.m., an interview was conducted with OSM (other staff member) #4, the director of social services. OSM #4 stated that the BIMS assessment should be attempted on all	F 641		

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F 641	Continued From page 62 residents. OSM #4 stated that R31's BIMS should be coded as a 15, being cognitively intact. OSM #4 reviewed the quarterly MDS with the ARD of 1/24/2022 and stated that they did not know why the BIMS was not completed. OSM #4 stated that they would review the record and determine why the assessment was not completed. On 4/13/2022 at 1:22 p.m., OSM #4 stated that they had reviewed R31's record and it appeared that the MDS had been signed off when the ARD was met prior to the BIMS assessment being completed. OSM #4 stated that the BIMS assessment should have been completed. On 4/14/2022 at 8:18 a.m., an interview was conducted with RN (registered nurse) #3, the MDS coordinator. When asked for a policy on completing Section C of the MDS, RN #3 stated there is no policy, they follow the RAI (resident assessment Instrument) manual. The CMS (centers for medicaid and medicare services) RAI manual documents the following: C0100: Should Brief Interview for Mental Status Be Conducted? Item Rationale Health-related Quality of Life ·Most residents are able to attempt the Brief Interview for Mental Status (BIMS). ·A structured cognitive test is more accurate and reliable than observation alone for observing cognitive performance. - Without an attempted structured cognitive interview, a resident might be mislabeled based on his or her appearance or assumed diagnosis... ·Code 1, yes: If the interview should be conducted because the resident is at least sometimes	F 641	4.) The Director of Nursing/designee will conduct an audit of 25% of resident's MDS weekly for four weeks to ensure that BIMS and Section C are completed and accurate. The Director of Nursing/designee will also audit the initial MDS of any new admissions daily for six weeks to ensure accuracy and completion of BIMS and Section C. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate corrective actions will be taken. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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EVERGREEN HEALTH AND REHAB	360 MILLWOOD AVENUE WINCHESTER, VA 22601

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F 641	Continued From page 63 understood verbally, in writing, or using another method... Coding Tips ·Attempt to conduct the interview with ALL residents. This interview is conducted during the look-back period of the Assessment Reference Date (ARD)..." The facility policy, "MDS Completion and Submission Timeframes" documented in part, "...1. The assessment coordinator or designee is responsible for ensuring that resident assessments are submitted to CMS's QIES Assessment Submission and Processing (ASAP) system in accordance with current federal and state guidelines. 2. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual..." On 4/13/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the findings. No further information was presented prior to exit. 2. The facility staff failed to complete Section C - Cognition, on the quarterly MDS (minimum data set) assessment, with an ARD (assessment reference date) of 3/15/2022 for Resident #110 (R110). On the most recent MDS (minimum data set) a quarterly assessment, with an ARD (assessment reference date) of 3/15/2022, the BIMS (brief interview for mental status) was not coded correctly. On the prior MDS assessment, an	F 641		

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F 641	Continued From page 64 admission assessment, with an ARD of 12/13/2021, the resident scored a 13 out of 15 on the BIMS score indicating the resident not cognitively impaired for making daily decisions. The quarterly MDS assessment with an ARD of 3/15/2022, in Section C - Cognitive patterns, the resident interview was coded to be completed. Under the resident interview questions, it was coded as "not assessed' for all of the questions for the BIMS. In Section C0600 - Should the Staff Interview be Conducted, "not assessed' was documented. An interview was conducted with OSM (other staff member) #4, the social worker, who is responsible for completing Section C of the MDS assessment, on 4/14/2022 at 8:18 a.m. OSM #4 was asked to review the above MDS assessment with an ARD of 3/15/2022, Section C. After reviewing it, OSM #4 stated, "I did that, I don't know why I marked not assessed. I know how to document if the resident refuses." When asked about the staff interview being coded as "not assessed," OSM #4 stated, "I don't know why I marked it as that. OSM #4 stated she was looking in the progress notes, that she normally writes when she does her part of the assessments, to see if she documented anything that would tell her why she coded it the way she did. After reviewing the progress notes, OSM #4 stated, "There is no note, I should and I usually do write a note." An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 4/14/2022 at 8:18 a.m. When asked for a policy on completing Section C of the MDS, RN #3 stated there is no policy, they follow the RAI (resident assessment	F 641		

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F 641	Continued From page 65 Instrument) manual. ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/13/2022 at 5:15 p.m. No further information was provided prior to exit.	F 641	**F656/12 VAC 5-371-250/ 12 VAC 5-371-250 (G)- Develop/Implement Comprehensive Care Plan** 1.) Resident #57 was assessed by nursing staff and their medical records were reviewed. The resident's care plans have been updated to reflect a current individualized plan of care. Evergreen Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee will perform an audit of residents who had a fall over the last 30 days to ensure that the Care plans have been updated to ensure individualized needs are addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified. 3.) The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary	
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.	F 656		

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F 656	Continued From page 66 (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for one of 45 residents in the survey sample, #57. The findings include: The facility staff failed to follow the comprehensive care plan to have fall mats on both sides of the bed for Resident #57. On the most recent MDS (Minimum Data Set), a 5-day assessment, with an ARD (Assessment Reference Date) of 2/9/22, Resident #57 scored a 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. The resident was coded as being dependent on staff for activities of daily living (ADL). On 4/12/22 at 12:55 PM, and on 4/13/22 at 4:00	F 656	team members regarding care plan updates. The in-service includes, but no limited to, the importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs. 4.) The Director of Nursing/designee will conduct an audit, of residents with a fall, weekly for four weeks to ensure that interventions are appropriate and reflect the individual needs of each resident in their care plan. The Director of Nursing/designee will also audit the care plans of any new admissions weekly for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans.	

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F 656	Continued From page 67 PM, Resident #57 was observed in bed. There was a fall mat on the door side of the bed (resident's left side.) There was no fall mat on the other side of the bed. A review of the comprehensive care plan revealed one dated 11/17/21 for "Resident is at risk for falls related to weakness and unsteady gait." This care plan included the intervention, dated 12/21/21 for "Floor mat to both sides of bed." On 4/13/22 at 4:04 PM an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked if a resident was care planned for fall mats on both sides of the bed and only had one fall mat, was the care plan being followed, they stated that it was not being followed. The facility policy, "Care Planning - Comprehensive Person-Centered" was reviewed. This policy documented, "2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process." On 4/13/22 at 5:00 PM at the end-of-day meeting with ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 656	The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	
F 657	Care Plan Timing and Revision	F 657		

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F 657 SS=E	Continued From page 68 CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to review and revise the comprehensive care plan for 3 of 45 residents in the survey sample; Residents #57, #16, and #54.	F 657	**F657/12 VAC 5-371-210/12VAC 5-371-250- Care Plan Timing and Revision** 1.) Residents #57, #16 and #54 were assessed by nursing staff and their medical records were reviewed. The residents' care plans have been updated to reflect a current individualized plan of care. Evergreen Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee will perform an audit of residents who had a fall over the last 30 days to ensure that the Care plans have been updated to ensure individualized needs are addressed appropriately. A process has been developed and implemented to identify resident care needs in the daily interdisciplinary team meeting, and to update the care plans to reflect the needs identified.	

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F 657	Continued From page 69 The findings include: 1. Facility staff failed to review and revise the comprehensive care plan after a fall on 1/8/22, for Resident #57. On the most recent MDS (Minimum Data Set), a 5-day assessment, with an ARD (Assessment Reference Date) of 2/9/22, Resident #57 scored a 8 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. The resident was coded as being dependent on staff for activities of daily living (ADL). A review of the clinical record revealed the following: A nurse's note dated 1/8/22 that documented, "1420 (2:40 PM)-at this time resident's roommate was yelling out 'HELP" and resident's alarms sounding, staff ran to room when approached doorway staff observed resident on floor, resident had fallen from w/c (wheel chair), when asked resident what happened [Resident #57] states "I was trying to go to the bathroom", resident states I hit my head, staff assisted resident into w/c VS (vital signs) as follows; B/P (blood pressure) 138/84, R (respirations) 22, P (pulse) 88, T (temperature) 98.0, O2 sat (oxygen saturation) 96% on room air, full assessment done with no injuries, MAEW (moves all extremities well) WNL (within normal limits), ROM (range of motion) WNL, resident c/o (complained of) bad h/a (headache) and back area hurting, called NP (nurse practitioner) to make aware of fall and issues with fall, received order to send resident out to ER (emergency room), 911 called resident	F 657	3.) The Director of Nursing/designee has in-serviced nursing leadership and interdisciplinary team members regarding care plan updates. The in-service includes, but no limited to, the importance of care plan reviews and updates with any changes for each resident and care plans being reflective of individualized care needs. 4.) The Director of Nursing/designee will conduct an audit, of residents with a fall, weekly for four weeks to ensure that interventions are appropriate and reflect the individual needs of each resident in their care plan. The Director of Nursing/designee will also audit the care plans of any new admissions weekly for six weeks to ensure that interventions are appropriate and reflect the individual needs of each resident. Any issues identified will be	

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F 657	Continued From page 70 was transported to [name of hospital] ER, called POA (power of attorney) and left message via voice mail." A second nurse's note dated 1/8/22 documented, "This nurse f/u (followed up) with pt (patient) in er (emergency room) [name of hospital]. Spoke to er nurse [name of hospital nurse], labs wnl (within normal limits], awaiting result from CT (computerized tomography) scan head neck and chest." A nurse practitioner note dated 1/10/22 documented, "resident attempted to get oob (out of bed) again this weekend and fell stating [Resident #57] hit head, on blood thinner. gave orders to sent to [name of hospital]. ct scan negative. [Resident #57] was sent back with cipro (1) and dx (diagnosed) with UTI (urinary tract infection) at hospital." A review of the comprehensive care plan revealed one dated 11/17/21 for "Resident is at risk for falls related to weakness and unsteady gait." There was no evidence this care plan was reviewed and revised after the above fall. On 4/13/22 at 3:30 PM, a list of requested documents was provided to the facility. This list included a request for the fall incident report of the above documented fall. On 4/13/22 at approximately 4:30 PM, ASM #2 (Administrative Staff Member) the Director of Nursing provided a print out of the above documented nurse's notes from the clinical record and stated that these notes was the investigation. The above notes did not evidence that the care plan was reviewed following this fall	F 657	addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the resident care plans. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 657	Continued From page 71 for identification of potential additional interventions to be added. On 4/13/22 at 4:04 PM an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked if a resident had a fall, should the comprehensive care plan be reviewed and possibly revised, they stated that it should be. The facility policy, "Care Planning - Comprehensive Person-Centered" was reviewed. This policy documented, "...2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process....15. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When requested by the resident / resident representative; b. When there has been a significant change in the resident's condition; c. When the desired outcome is not met; d. When goals, needs, and preferences change; e. When the resident has been readmitted to the facility from a hospital stay; and f. At least quarterly and after each OBRA MDS assessment." On 4/13/22 at 5:00 PM at the end-of-day meeting with ASM #1 the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. Reference: (1) Cipro - Ciprofloxacin is an antibiotic used to	F 657		

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F 657	Continued From page 72 treat or prevent certain infections. Information obtained from https://medlineplus.gov/druginfo/meds/a688016.html 2. The facility staff failed review and revise the comprehensive care plan for the use of side rails for Resident #16. On the most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment Reference Date) of 1/20/22, Resident #16 scored a 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. The resident was coded as being dependent on staff for activities of daily living (ADL). On 4/12/22 at 1:01 PM, Resident #16 was observed in bed with bilateral side rails up. A review of the clinical record revealed a side rail assessment dated 6/4/21 revealed the following relevant questions and responses: Question #1, "The resident/resident representative has requested use of the side rails." Question #2, "The resident is physically able to use the side rails for bed positioning or transfer independently or with assistance." Question #3, "The resident is able to recognize safety hazards when using the side rails." Question #9, "The use of a side rail will optimize resident Independendence [sic] in bed mobility and transfer."	F 657		

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F 657	Continued From page 73 Question #10, "The use of the side rail during care provided by staff will optimize resident safety and security." Question #17, "Resident's care plan addresses use of side rails and interventions to minimize injury or entrapment." The response of "Yes" was marked for each of the above questions. A review of the comprehensive care plan revealed one dated 11/1/16 for "The resident has an ADL self-care performance deficit r/t (related to) gait and mobility, muscle weakness and dementia" and one dated 7/18/17 and revised on 9/30/19 for "The resident is risk for falls r/t weakness, resident demonstrates impaired balance during transitions." Neither care plan contained any interventions for the use of side rails. Review of the remainder of the comprehensive care plan failed to reveal any evidence that the use of side rails was incorporated in any other section, either. On 4/13/22 at 4:04 PM an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked if a resident who is using side rails should be care planned for the use of side rails, they stated that it should be care planned. The facility policy, "Care Planning - Comprehensive Person-Centered" was reviewed. This policy documented, "...2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout	F 657		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 74 the comprehensive Resident Assessment Instrument (RAI) process....15. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When requested by the resident / resident representative; b. When there has been a significant change in the resident's condition; c. When the desired outcome is not met; d. When goals, needs, and preferences change; e. When the resident has been readmitted to the facility from a hospital stay; and f. At least quarterly and after each OBRA MDS assessment.". On 4/13/22 at 5:00 PM at the end-of-day meeting with ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. 3. The facility staff failed to review and revise the comprehensive care plan for Resident #54 after a pressure injury healed on 1/11/22. The wound care was still on the present active care plan at the time of the survey on 4/13/22. On the most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment Reference Date) of 2/5/22, Resident #54 scored a 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was severely cognitively impaired for making daily decisions. The resident was coded as being dependent on staff for activities of daily living (ADL). A review of the clinical record revealed a wound	F 657		

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F 657	Continued From page 75 care physician's evaluation dated 1/11/22 that documented the resident had a stage 2 pressure injury of the sacrum. The wound status was documented as "Resolved." A review of the comprehensive care plan revealed one dated 12/21/21 for "The resident has stage 2 pressure ulcer of the sacrum r/t (related to) immobility." This care plan was still in place as an active care plan at the time of survey on 4/13/22 even though the wound was documented as having healed on 1/11/22 and the resident did not have any current wounds at the time of the survey. On 4/13/22 at 4:04 PM an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked if a resident who had a wound, had a change of condition in that the wound had healed, should the care plan be revised to reflect that the wound had healed, or the care plan and related interventions be discontinued, they stated that it should be. The facility policy, "Care Planning - Comprehensive Person-Centered" was reviewed. This policy documented, "...2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument (RAI) process....15. The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans: a. When requested by the resident / resident representative; b. When there has been a significant change in the resident's condition; c.	F 657		

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F 657	Continued From page 76 When the desired outcome is not met; d. When goals, needs, and preferences change; e. When the resident has been readmitted to the facility from a hospital stay; and f. At least quarterly and after each OBRA MDS assessment." On 4/13/22 at 5:00 PM at the end-of-day meeting with ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 657		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews and facility document reviews it was determined that the facility staff failed to ensure 2 of 45 residents were free of safety hazards, Resident #56 and Resident #36. Resident #56 and #36's bed rails were observed to be visibly loose creating a potential safety hazard. The findings include: 1. The facility staff failed to ensure Resident #56's (R56) bed rail was not loose, creating a	F 689		

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F 689	Continued From page 77 potential safety hazard. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/8/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions. Section G documented R56 requiring extensive assistance from two or more staff members for bed mobility. On 4/12/2022 at 4:10 p.m., an observation was made of R56 in their room. R56 was observed in bed with bilateral upper bed rails on the bed. R56 stated that they used the bed rails to shift their weight and to keep an organizer on the rail which held some of their belongings. R56 stated that the left bed rail was loose and proceeded to shake the rail with their hand. R56 stated that they were waiting for someone to come in to tighten up with rail. R56 stated that the staff were aware that the rail was loose and that it had been loose for "a couple of weeks." The most recent maintenance bed inspection for R56's bed was reviewed and was completed on 2/21/2022. Review of R56's clinical record documented a bed rail consent dated 10/28/2020 and a side rail entrapment risk assessment dated 4/6/2021. The comprehensive care plan for R56 documented in part, "Resident requires assistance with ADLs (activities of daily living) r/t (related to) impaired mobility. Date initiated: 03/15/2019..."	F 689	free of Accident Hazards/Supervision/Devices 1.) Residents #36 and #56 have had their bed rails assessed by staff. The resident's bed rails have been replaced and the new bed rails were tested to ensure resident safety. Evergreen Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2.) The Administrator/designee has performed an assessment of all resident's bed rails to ensure that there are no loose rails which would create a safety hazard for residents. Any variances have been corrected by replacing the loose bed rails. Any new rails applied were tested to ensure resident safety. 3.) The Administrator/designee has in-serviced staff on the Maintenance Director and Nurses of providing an environment that is free of resident safety concerns. The in-service included, but was not limited to, performing bed rail assessments upon admission and bed changes, and performing routine assessments of bed rails on all	

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F 689	Continued From page 78 The facility maintenance director was on leave and not available for interview. On 4/13/2022 at 12:30 p.m., a telephone interview was conducted with OSM (other staff member) #10, regional maintenance. OSM #10 stated that a bed inspection and bed rail inspection was completed for the bed anytime a resident was moved. OSM #10 stated that each month a certain amount of beds were inspected and as needed beds were checked. OSM #10 stated that at a minimum, all beds were done annually. OSM #10 stated that there was a computer program used for staff to put work orders in which sent the work orders directly to the maintenance directors cellphone and computer to be completed. On 4/13/2022 at 12:39 p.m., ASM (administrative staff member) #1, the administrator observed the left bed rail in R56's room. ASM #1 observed the left rail on R56's bed when the resident shook it and stated that he would get it taken care of. R56 stated, "I don't want to fall out of bed." ASM #1 pulled on the rail and reassured R56 that the rail was safe and only need to be tightened up. On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that a bed rail assessment and consent was completed for residents who used bed rails. LPN #4 stated that any maintenance issues were reported directly to maintenance by a phone call or put into the computer. LPN #4 stated that they were not aware of any residents with loose bed rails but they would report them immediately because they were a safety hazard. LPN #4 stated that the resident could get their arm stuck in the rail or they could fall out of bed	F 689	beds in the facility to ensure the rails do not present a potential safety hazard to residents. .) The Administrator/designee will assess all one unit in the facility weekly for 6 weeks to ensure resident safety. The Administrator/designee has developed an ongoing system to routinely assess bed rails for safety. Any issues identified will be addressed immediately by Administrator/designee and appropriate actions will be taken to repair or replace the bed rails. The Administrator/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 689	Continued From page 79 and get injured. The facility policy "Bed Rail Risk and Safety" documented in part, "...This organization will take measures to develop and implement a strategy to minimize the possibility of resident entrapment and or injury while using bed rails..." On 4/13/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the above concern. No further information was provided prior to exit. 2. The facility staff failed to ensure Resident #36's (R36) bed rail was not loose, creating a potential safety hazard. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/1/2022, the resident scored 14 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident is cognitively intact for making daily decisions. Section G documented R36 requiring extensive assistance from two or more staff members for bed mobility. On 4/12/2022 at 3:54 p.m., an observation was made of R36 in their room. R36 was observed in bed with bilateral upper bed rails on the bed. R36 stated that did not use their bed rails anymore because they were loose. R36 stated that the left rail was the worst one and it "scares the hell out of me." R36 proceeded to shake the rail which	F 689		

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F 689	Continued From page 80 was visibly loose from the bed and stated that one of the nurses had told them that they were calling maintenance to come in to fix their bed rail and their roommates bed rail about a month ago but no one had ever come in. The most recent maintenance bed inspection for R36's bed was reviewed and was completed on 2/21/2022. Review of R36's clinical record documented a bed rail assessment/entrapment assessment dated 5/19/2021. The comprehensive care plan for R36 documented in part, "Resident requires extensive assistance with ADLs (activities of daily living) r/t (related to) decreased mobility. Date Initiated: 03/15/2019..." The facility maintenance director was on leave and not available for interview. On 4/13/2022 at 12:30 p.m., a telephone interview was conducted with OSM (other staff member) #10, regional maintenance. OSM #10 stated that a bed inspection and bed rail inspection was completed for the bed anytime a resident was moved. OSM #10 stated that each month a certain amount of beds were inspected and as needed beds were checked. OSM #10 stated that at a minimum, all beds were done annually. OSM #10 stated that there was a computer program used for staff to put work orders in which sent the work orders directly to the maintenance directors cellphone and computer to be completed. On 4/13/2022 at 12:39 p.m., ASM (administrative	F 689		

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F 689	Continued From page 81 staff member) #1, the administrator observed the left bed rail in R36's room. ASM #1 observed the left rail on R36's bed when the resident shook it and stated that it needed to be tightened up. ASM #1 attempted to tighten the left bed rail on the bed and stated that he would have someone come in to look at the bed rail and get it taken care of. On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that a bed rail assessment and consent was completed for residents who used bed rails. LPN #4 stated that any maintenance issues were reported directly to maintenance by a phone call or put into the computer. LPN #4 stated that they were not aware of any residents with loose bed rails but they would report them immediately because they were a safety hazard. LPN #4 stated that the resident could get their arm stuck in the rail or they could fall out of bed and get injured. On 4/13/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the above concern. No further information was provided prior to exit.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		

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F 695	Continued From page 82 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews and facility document review it was determined that the facility staff failed to administer oxygen as ordered to two of 45 residents in the survey sample, Resident #93 and #117. The findings include: 1. The facility staff failed to administer oxygen as ordered and in a sanitary manner to Resident #93 (R93). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/13/2022, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident is moderately impaired for making daily decisions. R93 was coded as using oxygen while a resident at the facility. An observation on 4/12/2022 at 1:22 p.m., revealed R93 in bed. An oxygen nasal cannula was observed lying in the floor to the left side of R93's bed. The oxygen concentrator was observed to be on with the oxygen set at 2 lpm (liters per minute). When asked about the oxygen, R93 stated that they wore the oxygen sometimes, R93 stated that the nurses put the cannula on them. When asked if R93 ever removed the oxygen themselves, R93 stated, "No."	F 695	**F695/12 VAC 5-371-220 (A)- Respiratory/Tracheostomy Care and Suctioning** 1.) Oxygen orders for resident #93 have been reviewed and clarified and the resident is receiving the correct amount of oxygen per the provider orders and the oxygen tubing is correctly dated and stored in a sanitary manner. The residents' plans of care were reviewed and updated to include resident-specific needs. Resident #117 is not currently a resident of Evergreen Health and Rehab, therefore no interventions were appropriate at this time. Evergreen Health and Rehab has identified that all residents are at risk from this alleged deficient practice.	

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F 695	Continued From page 83 Additional observations on 4/12/2022 at 2:45 p.m., 4:18 p.m. and 4/13/2022 at 8:05 a.m. revealed the same observation as stated above. The position of the nasal cannula remained in the floor to the left side of R93's bed with the concentrator running oxygen set at 2 lpm. Staff were observed entering and exiting R93's room providing care and services, upon exit the nasal cannula remained on the floor to the left side of the bed with the concentrator running at 2 lpm. The physician orders documented in part, "Oxygen at 2 liters per minute, verify O2 (oxygen) setting at eye level. Order Date: 3/7/2022." The comprehensive care plan for R93 documented in part, "The resident has altered respiratory status/difficulty breathing AEB (as evidenced by) O2 via NC (nasal cannula) continuous. Date Initiated: 03/07/2022." On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that oxygen was checked whenever they went into the room. LPN #4 stated that if a resident was not using their oxygen, they stored it in a plastic bag to keep it clean. LPN #4 observed R93's room, observed the nasal cannula that was previously observed on the floor to the left of the bed on the bed under R93's left arm. LPN #4 was made aware of the observations on 4/12/2022 and 4/13/2022 at 8:05 a.m., and stated that at times, R93 took the cannula on and off and threw it on the floor. LPN #4 stated that they should be documenting those behaviors in the medical record and notifying the physician. LPN #4 stated that R93 tells them he does not need the oxygen when he takes it off.	F 695	2.) An observation audit of resident oxygen administration amounts was performed on residents receiving oxygen and the amounts were compared to the provider's orders. The observation included ensuring that oxygen tubing was properly dated and stored in a sanitary manner. Any discrepancies were immediately corrected, and orders were verified or clarified with the provider. 3.) The Director of Nursing/designee has in-serviced licensed nurses (RNs and LPNs) regarding oxygen administration and sanitary storage. The in-service includes, but is not limited to, the importance of administering oxygen per provider's orders and clarifying oxygen orders if there is any variance between what is ordered and what is stated elsewhere in the medical record, as well as sanitary storage of oxygen tubing.	

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F 695	Continued From page 84 LPN #4 stated that the staff should be checking the oxygen each time they enter the room to provide care and storing the cannula in a plastic bag if R93 was refusing to wear it. The facility policy "Oxygen Administration" documented in part, "...If the resident refused the procedure, the reason(s) why and the intervention taken..." On 4/13/2022 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to provide respiratory therapy as ordered for Resident #117. Resident #117 was observed with the nasal cannula oxygen set at four liters nasal cannula on 4/12/22 at 1:30 PM, 4/12/22 at 4:15 PM and on 4/13/22 at 8:25 AM.. Resident #117 was admitted to the facility on 3/22/22 with diagnoses that include but are not limited to: Congestive heart failure, atrial fibrillation and atherosclerotic cardiovascular disease. Resident #117's most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an assessment reference date of 3/28/22, coded the resident as scoring 10 out of 15 on the BIMS (brief interview for mental status score),	F 695	4.) The Director of Nursing/designee will perform an audit to compare all oxygen orders to amounts administered weekly for six weeks to ensure that oxygen is being administered as per provider orders. The Director of Nursing/designee will perform observation audits of all residents receiving oxygen weekly for six weeks to ensure that tubing is dated and stored in a sanitary manner. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 695	Continued From page 85 indicating the resident was moderately cognitively impaired. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, toileting, bathing and personal hygiene; supervision with eating. Resident #117's care plan dated 4/1/22, revealed the following, "Focus: Resident is receiving hospice for end of life care. Interventions: Utilize oxygen for shortness of breath and comfort." A review of the physician's orders dated 3/22/22, revealed the following, "Oxygen at 2 liters per minute via nasal cannula. Verify oxygen setting at eye level." A review of Resident #117's April 2022 TAR (treatment administration record), which reveals, "Oxygen at 2 liters per minute via NC Due to Diagnosis of: verify O2 setting at eye level every shift" with documentation for all three shifts. From 4/1/22-4/12/22. An interview was conducted with Resident #117 on 4/12/22 at 4:15 PM. When asked about her oxygen setting, Resident #117 stated, "I use it all the time. It helps with my breathing. I think it is set on two but I am not sure. An interview was conducted on 4/13/22 at 8:25 AM with LPN (licensed practical nurse) #4. When asked what the oxygen for Resident #117's was set on, LPN #4 bent down to review oxygen setting and stated, Her oxygen is set at 4 liters nasal cannula. It should be at 2 liters nasal cannula. The orders are for 2 liters nasal cannula. LPN #4 adjusted the oxygen setting to 2 liters nasal cannula. When asked how you should read the oxygen setting, LPN #4 stated,	F 695		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 86 the ball should be in the middle of the line and we should be viewing at eye level. On 4/13/22 at 5:00 PM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were informed of the above concern. According to the facility's "Oxygen Administration" policy with no date, which revealed the following, "Review the physician's orders or facility protocol for oxygen administration." According to the oxygen concentrator's user manual, which reveals, "To set the flow of supplemental oxygen, turn the knob of oxygen flow meter switch left or right until the ball inside the flow meter centers on the flow line number and the prescribed oxygen flow." No further information was provided prior to exit.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior	F 700		

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	495142	A. BUILDING _____ B. WING _____	C 04/14/2022

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F 700	Continued From page 87 to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, resident interviews, staff interviews, clinical record reviews and facility document review it was determined that the facility staff failed to assess 2 of 45 residents in the survey sample for the use of bed rails, Resident #93 and #54. The findings include: 1. The facility staff failed to evidence an assessment for the use of bed rails for Resident #93 (R93). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/13/2022, the resident scored 11 out of 15 on the BIMS (brief interview for mental status) assessment indicating the resident is moderately impaired for making daily decisions. R93 was coded as requiring extensive assistance of two or more staff members for bed mobility. An observation on 4/12/2022 at 1:22 p.m., revealed R93 in bed with bilateral mid bed rails up on the bed. When asked about the bed rails, R93 stated that they use them to turn in bed. Additional observations on 4/12/2022 at 2:45 p.m., 4:18 p.m. and 4/13/2022 at 8:05 a.m.	F 700	**F700- Bedrails** 1.) Bed rail assessments were completed for residents #93 and #54. The residents' care plans have been updated to reflect a current individualized plan of care. Evergreen Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2.) The Director of Nursing/designee has performed an assessment audit of all current residents to ensure that bed rail assessments have been completed. Any variances have been addressed and care plans have been updated to reflect a current individualized plan of care. 3.) The Director of Nursing/designee has in-serviced licensed nursing staff, including LPNs and RNs, regarding completion of bedrail assessments. The in-service includes, but no limited to, the importance of completing the bedrail assessment in a timely and accurate manner to ensure resident safety.	

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F 700	Continued From page 88 revealed the same observation as stated above. Review of R93's clinical record failed to evidence documentation of an assessment for the use of bed rails. The comprehensive care plan for R93 documented in part, "The resident has an ADL (activities of daily living) self-care performance deficit AEB (as evidenced by) left side weakness, generalized weakness, recent hospitalization. Date Initiated: 03/07/2022... SIDE RAILS: half rails up for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury..." On 4/13/2022 at 10:12 a.m., a request was made via a written list to ASM (administrative staff member) #1, the administrator for the bed rail assessment, bed inspection and consent for use of bed rails for R93. On 4/13/2022 at approximately 1:00 p.m., ASM #2, the director of nursing provided a bed inspection completed by maintenance for R93's bed on 2/21/2022, and an admission agreement with a bed rail consent dated 3/8/2022 but no bed assessment. On 4/13/2022 at 12:40 p.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that a bed rail assessment was completed in the computer for residents prior to them using bed rails and they had them sign a consent. LPN #4 stated that the bed rail assessment was completed on admission or before bed rails were put into use and then again quarterly.	F 700	the Director of Nursing/designee and appropriate corrective actions will be taken. The Director of Nursing/designee will identify any trends and/or patters and provide education and training to staff on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 700	Continued From page 89 On 4/13/2022 at 2:00 p.m., ASM #2 stated that R93 should have a side rail/Entrapment assessment completed in the medical record and they did not have one to provide. The facility policy "Bed Rail Risk and Safety" documented in part, "...Any resident being considered for using a bed with bed rail(s) is evaluated by the facility's interdisciplinary team to determine whether the resident's functional status and bed mobility is improved through the use of bed rail(s), to identify any bed rail that might constitute physical restrain, and to identify individual characteristics that may increase the risk of entrapment by bed rails or mattress. The bed rail evaluation, including the entrapment risk component, is completed: a. Admission, Readmission..." On 4/13/2022 at approximately 5:00 p.m., ASM #1, the administrator, ASM #2, the director of nursing, and ASM #4, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to complete a side rail evaluation prior to implementing the use of side rails for Resident #54. On the most recent MDS (Minimum Data Set), a quarterly assessment, with an ARD (Assessment Reference Date) of 2/5/22, Resident #54 scored a 3 out of 15 on the BIMS (brief interview for mental status), indicating the resident was	F 700		

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F 700	Continued From page 90	F 700		

severely cognitively impaired for making daily decisions. The resident was coded as being dependent on staff for activities of daily living (ADL).

On 4/12/22 at 12:57 PM and on 4/13/22 at 4:00 PM, Resident #54 was observed in bed. The resident had bilateral padded side rails up.

A review of the physician's orders revealed one dated 2/28/22 for "padded side rails."

A review of the comprehensive care plan revealed one dated 10/7/21 for "The resident has an ADL self-care performance deficit r/t (related to) Impaired balance, Limited Mobility, hx (history) of Parkinson's." Interventions included one dated 10/7/21 for, "SIDE RAILS: half rails up as per Dr.s (doctor's) order for safety during care provision, to assist with bed mobility. Observe for injury or entrapment related to side rail use. Reposition as necessary to avoid injury."

Further review of the clinical record failed to reveal any evidence of a side rail evaluation being completed prior to the use of the side rails.

On 4/13/22 at 4:04 PM an interview was conducted with LPN #3 (Licensed Practical Nurse). When asked if a resident was using side rails, should there be a side rail assessment completed prior to using them, they stated that it should be.

The facility policy, "Bed Rail Risk and Safety" was reviewed. This policy documented, "This organization will take measures to develop and implement a strategy to minimize the possibility of resident entrapment and or injury while using bed

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F 700	Continued From page 91 rails. This will include an evaluation of residents who have a need for or desire to use bed rails and that may have characteristics that place them at special risk for entrapment....Assess the Resident: 1. Any resident being considered for using a bed with bed rail(s) is evaluated by the facility's interdisciplinary team to determine whether the resident's functional status and bed mobility is improved through the use of bed rail(s), to identify any bed rail that might constitute physical restraint, and to identify individual characteristics that may increase the risk of entrapment by bed rails or mattress." On 4/13/22 at 5:00 PM at the end-of-day meeting with ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 700		
F 730 SS=E	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to complete an annual CNA (certified nursing aide) performance review for five of five CNA record reviews.	F 730		

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F 730	Continued From page 92 The facility staff failed to complete an annual performance review for CNA #2, CNA #3, CNA #4, CNA #5 and CNA #6. The findings include: CNA #2 was hired on 3/30/21. A review of CNA #2's record failed to reveal any performance reviews. CNA #3 was hired on 3/18/19. A review of CNA #3's record failed to reveal any performance reviews. CNA #4 was hired on 5/6/13. A review of CNA #4's record revealed the last performance review was completed on 10/1/18. CNA #5 was hired on 11/27/09. A review of CNA #5's record revealed the last performance review was completed on 9/20/18. CNA #6 was hired on 8/1/99. A review of CNA #6's record revealed the last performance review was completed on 9/5/18. On 4/13/22 at 1:58 p.m., an interview was conducted with ASM (administrative staff member) #2 (the director of nursing). ASM #2 stated performance reviews should be done annually. ASM #2 stated the human resources director keeps a record of when employees' annual performance reviews are due and gives her a list of performance reviews that need to be done. ASM #2 stated that usually she completes the reviews or delegates them to the assistant director of nursing or a nurse on the unit. ASM #2 stated that once the review is done and reviewed/approved by the administrator, the	F 730	**F730- Nurse Aide Performance Review** 1. The facility has completed annual performance reviews for CNAs #2, #3, #4, #5 and #6. In-service education was provided to the CNAs based on the outcome of the reviews. Evergreen Health and Rehab has determined that all residents have the potential to be affected by this alleged deficient practice. 2. The Director of Nursing/designee has completed an audit of 12-month performance reviews for all CNAs currently employed by the facility. Any variances found have been corrected and all currently employed CNAs have had a 12-month performance review completed.	

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F 730	Continued From page 93 review is given to the human resources director to be filed. The human resources director was no longer employed at the facility. On 4/13/22 at 5:02 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Performance Evaluations" documented, "The job performance of each employee shall be reviewed and evaluated at least annually." No further information was presented prior to exit.	F 730	3. The Director of Nursing/designee has in-serviced nursing management and Human Resources staff on the importance of conducting annual CNA performance reviews and providing in-service education based on the outcome of the reviews. The education included, but was not limited to, procedure for conducting the annual performance review, performance benchmarks, and identifying areas of CNA performance requiring in-service education.	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a	F 732	4. The Director of Nursing/Designee will perform an audit of annual CNA performance reviews monthly for three months to ensure that the reviews are completed, and in-service education is provided based on the outcome of the reviews. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 5/16/2022	

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F 732	Continued From page 94 daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post complete nurse staffing information. Nurse staffing information posted on 4/13/22 failed to document the facility name and failed to separate the actual hours and total number of RNs (registered nurses) and LPNs (licensed practical nurses). The findings include: On 4/13/22 at 10:15 a.m., the nurse staffing information posting was observed in the lobby hall. The posting failed to document the facility name and failed to separate the actual hours and total number of RNs and LPNs. The actual hours and total number of RNs and LPNs were combined.	F 732	**F732- Posted Nurse Staffing Information** 1.) Facility staff have corrected this alleged deficient practice. The daily nursing staff report is being posted at the nurses' station daily with documentation of the facility name and separated actual hours and total number of RNs (registered nurses) and LPNs (licensed practical nurses). 2.) Director of Nursing/designee has reviewed daily nursing staff report and ensured that it was posted visible to the public daily. Audits of posting have been performed since 5/1/22 and results are being tracked and variances addressed appropriately by Director of Nursing/designee. 3.) The Director of Nursing/designee has in-serviced the staffing coordinator and nurse managers on posting accurate daily staffing numbers. The in-service includes but is not limited to, how to accurately complete the daily nursing staff report and where to post this information so that it is visible to general public.	

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F 732	Continued From page 95 On 4/13/22 at 1:25 p.m., an interview was conducted with OSM (other staff member) #6 (the person responsible for the posting). OSM #6 stated she should date the posting, document the resident census on the posting, document the total number of RNs, LPNs, TNAs (temporary nursing assistants) and CNAs (certified nursing assistants) then document the total number of hours for each position. OSM #6 stated the posting should separate RNs and LPNs for the total number and actual hours. OSM #6 further stated the posting should document the facility name and she did not realize this was not documented. On 4/13/22 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, "Posting Direct Care Daily Staffing" documented, "3. Shift staffing information shall be recorded on the facility designated form for each shift. The information recorded on the form shall include the following: a. The name of the facility. b. The date for which the information is posted. c. The resident census at the beginning of the shift for which the information is posted. d. Twenty-four (24)-hour shift schedule operated by the facility. e. The shift for which the information is posted. f. Type (RN, LPN, LVN, or CNA) and category (licensed or non-licensed) of nursing staff working during that shift. g. The actual time worked during that shift for each category and type of nursing staff. h. Total number of licensed and non-licensed	F 732	4.) The Director of Nursing/designee will review daily postings for placement and accuracy weekly for six weeks. Any issues identified will be addressed immediately by the Director of Nursing/designee and appropriate action will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5.) Date of Compliance: 5/16/2022	

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F 732	Continued From page 96 nursing staff working for the posted shift. i. Any additional information required by state regulation/guidance." No further information was presented prior to exit.	F 732	**F812- Food Procurement, Store/Prepare/Serve-Sanitary** 1. Certified Dietary Manager/Cook has performed a walk-through inspection and discarded out-of-date items and has ensured all products were sealed and labeled correctly. It is the policy of Evergreen Health and Rehab to ensure food is procured, stored, and prepared in a sanitary manner. Residents receiving meals from the kitchen have the potential to be affected by this alleged deficient practice. 2. The Certified Dietary Manager/designee has performed morning and evening walk-through inspections to verify all items are sealed, labeled, and dated per policy. Any items found out of compliance have been discarded. 3. The Certified Dietary Manager/designee has re-educated culinary staff on the proper labeling/dating/sealing of stored food as per policy. The education included, but was not	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store food in a sanitary manner in 1 of 1 facility kitchens. The findings include: On 4/12/22 at approximately 12:15 PM, the kitchen tour was conducted with OSM #7 (Other	F 812		

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F 812	Continued From page 97 Staff Member) the Dietary Manager. The reach-in fridge was identified to contain a pan of bacon and sausage, a pan of beef patties, a pan of ground beef, a pan of tomato soup, and a pan of creamed corn, all which were not labeled and dated. This reach-in fridge also contained a pan of pancakes and toast and a pan of scrambled eggs, neither which were properly covered. Both pans had plastic wrap over them, which was pulled back on one side, exposing the food items to the environment of the reach-in fridge. A walk-in fridge contained a box of lettuce that were bagged. A bag was open with lettuce sticking out, exposing the lettuce to the environment in the walk-in fridge. On 4/12/22 at approximately 12:30, OSM #7 stated that these items should be covered, labeled and dated. The facility policy "Receiving and Storage of Food" was reviewed. This policy documented, "All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date)." On 4/13/22 at 5:00 PM at the end-of-day meeting with ASM #1 (Administrative Staff Member) the Administrator, and ASM #2 the Director of Nursing were made aware of the findings. No further information was provided by the end of the survey.	F 812	limited to, sanitary food storage, labeling, dating, and wasting of out-of-date food. 4. Certified Dietary Manager/designee will perform AM/PM walk-through audits daily for the next six weeks to ensure compliance is achieved. Any variances identified will be immediately corrected and further education will be provided to staff regarding prevention of these variances. Certified Dietary Manager will present audit findings and any trends/patterns to the QAPI committee on a quarterly basis. 5. Date of Compliance: 5/16/2022	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information.	F 842		

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F 842	Continued From page 98 (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.	F 842	**F842/12VAC5-371-360(E)(9)-Resident Records - Identifiable Information** 1. Resident #31 was assessed and interviewed by nursing staff and the resident's provider and representative were made aware of the missing documentation of insulin administration. The resident's plan of care was reviewed and updated to reflect their resident-specific needs regarding resident's right and preference pertaining to refusal of medications. Evergreen Heath and Rehab has identified that all residents are at risk from this alleged deficient practice. 2. The Director of Nursing/designee has audited the Medication Administration Record of residents with insulin orders current residents. Nursing has notified residents, responsible parties and provider any variances, and has ensured that care plan interventions are appropriate and address resident specific care needs regarding resident's right and preference pertaining to refusal of medications.	

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F 842	Continued From page 99 §483.70(l)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, facility document review and staff interview it was determined that the facility failed to maintain a complete and accurate clinical record for one of 45 residents in the survey sample, Resident #31 (R31). The findings include: The facility staff failed to maintain a complete and accurate clinical record documenting insulin administration for R31.	F 842	1. The Director of Nursing/designee has educated clinical staff, including RNs and LPNs regarding complete and accurate documentation in medication administration records. The education includes, but is not limited to, the importance of accurate and complete documentation of medications administered, and how to document a resident refusal of a medication or if a medication is not administered. 4. The Director of Nursing/designee will audit 25% of the Medication Administration Record (MAR) for residents with Insulin orders weekly for six weeks to ensure that documentation is accurate and complete. Any issues identified will be addressed immediately by Director of Nursing/designee and appropriate actions will be taken. The Director of Nursing/designee will identify any trends and/or patterns, and provide education as needed on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 5/16/2022	

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F 842	Continued From page 100 On the most recent MDS (minimum data set), a quarterly assessment with an ARD (Assessment Reference Date) of 1/24/2022, the BIMS (brief interview for mental status) assessment was not completed. On the previous quarterly assessment with an ARD of 12/30/2021 the resident scored 15 out of 15 on the BIMS assessment, indicating the resident is not cognitively impaired for making daily decisions. The physician orders for R31 documented in part, - "11/27/2020 Insulin Aspart FlexPen Solution Pen-Injector 100 Unit/ML (milliliter), Inject subcutaneously before meals related to Type 2 Diabetes Mellitus with Diabetic Neuropathy Unspecified." The eMAR (electronic medication administration record) dated 3/1/2022-3/31/2022) for R31 failed to evidence documentation for the Insulin Aspart FlexPen Solution Pen-Injector on the following dates, on 3/5/3022 at 6:30 a.m., 3/6/2022 at 6:30 a.m., 3/11/2022 at 6:30 a.m., 3/23/2022 at 6:30 a.m., and 3/27/2022 at 6:30 a.m." The areas for the administration of the medication on these dates and times were blank. The eMAR dated 4/1/2022-4/30/2022 for R31 failed to evidence documentation for the Insulin Aspart FlexPen Solution Pen-Injector on the following dates, on 4/7/2022 at 6:30 a.m. The area for the administration of the medication on 4/7/2022 was blank. The progress notes for R31 failed to evidence documentation regarding the Insulin Aspart FlexPen Solution Pen-Injector on the dates and times listed above.	F 842		

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F 842	Continued From page 101 On 4/14/2022 at 7:44 a.m., an interview was conducted with LPN (licensed practical nurse) #4. LPN #4 stated that they were not sure what the blank areas on the eMAR were. LPN #4 reviewed the eMAR for R31 dated 3/1/20222-3/31/2022 with blanks on the dates listed above. LPN #4 stated that R31 may have refused the medication but there should be something in the box documenting the refusal. On 4/14/2022 at 7:50 a.m., an interview was conducted with LPN #1. LPN #1 stated that blanks on the eMAR may mean that the resident may have been sleeping or may have refused the medication. LPN #1 stated that there should be a progress note that auto generates documenting the reason for the blank on the eMAR. On 4/14/2022 at 8:30 a.m., an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 reviewed the eMAR's dated 3/1/2022-3/31/2022 and 4/1/2022-4/30/2022 with the blanks on the dates listed above and stated that the areas means that either R31 was not in the building or that R31 refused the medication. ASM #2 stated that there should be initials in the blanks and documentation if R31 refused the medication or did not receive it. ASM #2 stated that if there were no progress notes or documentation on the eMAR they could not say whether it was refused, given or not given based on the practice that they evidence administration by documenting it on the eMAR. ASM #2 stated that the record was not complete because the staff were not completing the documentation. The facility policy "Administration Procedures for All Medications" dated 09/2018 documented in	F 842		

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F 842	Continued From page 102 part, "...After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR (medication administration record) or TAR (treatment administration record) and the controlled substance sign out record, if necessary..." On 4/14/2022 at approximately 8:35 a.m., ASM #2, the director of nursing and ASM #4, the regional nurse consultant were made aware of the findings. No further information was provided prior to exit.	F 842		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	

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F 880	Continued From page 103 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	1.) RN #2 was educated on appropriate use of PPE during medication administration pass on 4/13/22. The DON/designee has performed a root cause analysis with the assistance of the Infection Preventionist, QAPI team and governing body. The root cause analysis included a review of the facility's current infection control policies and procedures, including guidance from the CDC (Center for Disease Control)'s "Recommended practices for preventing bloodborne pathogens transmission during blood glucose monitoring and insulin administration in healthcare settings". The analysis shows the root cause to be that RN#2 did not typically pass medication as she worked in the MDS department and lacked education on PPE use during a medication pass administration. The facility pharmacy policy for injectable medications has been reviewed and does include the use of gloves during insulin administration. Licensed nurses including those that do not	

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F 880	Continued From page 104 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to follow infection control practices for one of six residents in the medication administration observation, Resident #16. The findings include: The facility staff failed to wear gloves when administering two insulin injections to Resident #16 (R16). On the most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 1/20/2022, the resident scored a 3 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is severely cognitively impaired for making daily decisions. The physician orders dated, 3/2/2022, documented, "Levemir solution (a long acting insulin used to treat people with type 1 and 2 diabetes) (1) 100 UNIT/ML (milliliter); inject 46 units subcutaneously in the morning for DM (diabetes mellitus)." The physician order dated 3/3/2022, documented, Novolog (a short acting insulin used to treat people with type 1 and 2 diabetes)(2) FlexPen Solution Pen-injector 100 UNIT/ML; inject 5 units subcutaneously in the morning for DM."	F 880	typically pass medications will receive a medication pass competency observation which will include an evaluation of infection control practices during injections. 2.) An infection prevention and intervention plan consistent with the requirements of 42 CFR 483.80 has been implemented for all facility residents. The Local Health District has been contacted and has been asked to assist regarding infection control practices. The Local Health District has been given immediate access to the facility for onsite inspections to ensure the facility's compliance with federal long term care participation requirements for Medicare/Medicaid programs. 3.) The Director of Nursing/designee has educated all licensed staff regarding medication administration and required PPE with medication administration. A competency was completed for facility licensed staff and was validated by the RNC. Facility licensed nurses will complete the	

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F 880	Continued From page 105 The medication administration observation was conducted on 4/13/2022 at 8:27 a.m. with RN (registered nurse) #2. RN #2 was administering insulin to R16. RN #2 drew up the Levemir insulin in the syringe. RN #2 proceeded to R16's room. RN#2 did not have gloves on. She proceeded to administer the Levemir into R16's left arm. RN #2 returned to the medication cart, disposed of the needle and used hand sanitizer. RN #2 proceeded to review the next order for Novolog. She pulled the FlexPen out of the medication cart. She set the flexpen for the 5 units. RN #2 proceeded to R16's room, again no gloves on. RN #2 administered the Novolog insulin into the resident's right arm. No gloves on during the administration of either of the insulin injections. An interview was conducted with RN #2 on 4/13/2022 at 1:37 p.m. When asked is she supposed to wear gloves when giving an injection, RN #2 stated she had never worn gloves when giving an injection. She stated she only used gloves when she drew blood. An interview was conducted with RN #4, the staff educator/infection preventionist, on 4/13/2022 at 1:48 p.m. When asked when giving an insulin injection should the nurse wear gloves, RN #4 stated, yes. Review of the facility policy, "Insulin Administration" failed to evidence documentation regarding the use of gloves when administering the insulin injections. The CDC (center for disease control)'s "Recommended Practices for Preventing Bloodborne Pathogen Transmission during Blood Glucose Monitoring and Insulin Administration in	F 880	education and competency by May 13, 2022. Documentation of staff competency is available in the facility for review. 4.) The Director of Nursing/designee will complete observation of medication pass per week for four weeks and then observation medication passes monthly for two ensure proper infection control practices (including PPE) are used during Medication Administration pass. The Director of Nursing/designee will identify any trends and/or patterns, and additional education and training will be provided to employees on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. Date of Compliance: 5/16/2022	

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F 880	Continued From page 106 Healthcare Settings" documented in part, "Wear gloves during blood glucose monitoring and during any other procedure that involves potential exposure to blood or body fluids." ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #4, the regional nurse consultant, were made aware of the above concern on 4/13/2022 at 5:15 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a606012.html (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a605013.html,	F 880		
F 947 SS=D	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may	F 947		

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F 947	Continued From page 107 address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, it was determined that the facility staff failed to ensure CNAs (certified nursing aides) completed required annual in-service training for two of five CNA record reviews. The facility staff failed to ensure CNA #4 and CNA #6 completed annual dementia training. The findings include: CNA #4 was hired on 5/6/13. A review of CNA #4's record failed to reveal evidence that the CNA had completed dementia training. CNA #6 was hired on 8/1/99. A review of CNA #6's record failed to reveal evidence that the CNA had completed dementia training. On 4/13/22 at 3:13 p.m., an interview was conducted with RN (registered nurse) #4 (the staff educator). RN #4 stated dementia training should be completed annually and due to a change in facility ownership and COVID-19, she was behind on making sure CNAs were doing required trainings. On 4/13/22 at 5:02 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.	F 947	**F947/VAC 5-371-260 (G) – Required In-Service Training for Nurse Aides** 1. The facility has completed annual dementia training for CNAs #4 and #6. 2. The Director of Nursing/designee has conducted an audit of annual dementia training. Annual dementia training has been completed for all CNAs currently employed by the facility. Any variances found have been corrected and all currently employed CNAs have had annual dementia training. 3 The Director of Nursing/designee has in-serviced nursing management and Human Resources staff on the importance of conducting annual CNA dementia training. The education included, but was not limited to, procedure for conducting the annual dementia training and identifying areas of CNA performance requiring additional in-service education. 4 The Director of Nursing/Designee will perform an audit of annual CNA dementia training weekly for 6 weeks and then monthly for 2 months to ensure that the	

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F 947	Continued From page 108 The facility policy titled, "Nurse Aide In-Service Training Program" documented, "4. Annual in-services: f. include training in dementia management..." No further information was presented prior to exit.	F 947	reviews are completed, and in-service education is provided. The Director of Nursing/designee will identify any trends and/or patterns and additional education and training will be provided on an ongoing basis. Findings will be discussed with the QAPI committee on at least a quarterly basis. 5. Date of Compliance: 5/16/2022	