PRINTED: 04/22/2022 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		495142	B. WING			C		
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	/14/2022	
		_		l	180 MILLWOOD AVENUE			
EVERGR	EEN HEALTH AND REHA	В			VINCHESTER, VA 22601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		(X5) COMPLETION DATE	
					DEFICIENCY)			
E 000	Initial Comments		Ε¢	000	This Plan of correction is			
	A				respectfully submitted as			
		ergency Preparedness d 4/12/22 through 4/14/22.			evidence of alleged complian			
		stantial compliance with 42			- ·	ice.		
	CFR Part 483.73, Reg	uirement for Long-Term			This submission is not an			
l	Care Facilities,				admission that the deficienc	es		
F 000	INITIAL COMMENTS		FO	000	existed or that we are in			
					agreement with them. It is a	n		
		licare/Medicaid survey was			affirmation that corrections	o		
	conducted 4/12/22 thro				the areas cited have been ma	ade		
		79 unsubstantiated and intiated) were investigated	-		and the facility is in compliar	ce		
		rrections are required for			with participation requireme			
		R Part 483 Federal Long					i	
	Term Care requiremen	ts. The Life Safety Code						
	survey/report will follow	v.		ĺ		,		
	The census in this 176	bed certified facility was	İ		F578/12VAC5-371-240(C)(10	* I		
		survey. The survey sample			Request/Refuse/Discontinue			
1	included forty current re	esidents and five closed			Treatment; Formulate Adva	rced		
i	record reviews.		]		Directive			
		nue Trmnt;Formite Adv Dir	F 5	78	4.3. Advance Discosting to 1			
SS=E	CFR(s): 483.10(c)(6)(8)	)(g)(12)(i)-(v)			1.) Advance Directives have been		İ	
	\$483.10(c)(6) The right	to request, refuse, and/or			formally discussed with resid	i		
		to participate in or refuse			#110, #47, #50, #61, #111, ar			
	to participate in experin	nental research, and to	1		#58 and their medical record	5		
	formulate an advance of	lirective.			have been updated to reflect		-	
	8493 10/a\/9\ Nathing :	n this paragraph should be			their choices. Evergreen Heat	h		
1	construed as the right of	of the resident to receive			and Rehab has identified that	all		
- 1	the provision of medical	treatment or medical			residents are at risk from not			
	services deemed medically unnecessary or			}	having a discussion regarding			
	inappropriate.				their advance directives.	İ	N.	
	8483 10(n)(12) The foci	lity must comply with the						
	requirements specified							
	subpart I (Advance Dire							
BORATORY DI	DECTADIS AS DEAVIDEDISHE	PPI IER REPRESENTATIVE'S SIGNATURE			nne			

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				С	
	495142	B. WING		04/14/2022	
NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAE	3		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
residents concerning to medical or surgical treesident's option, form:  (ii) This includes a writted facility's policies to imperent and applicable State later (iii) Facilities are permited entities to furnish this integrally responsible for requirements of this set (iv) If an adult individuate time of admission and information or articulate has executed an advart may give advance direct individual's resident requirements of the set of the information or she is able to receive Follow-up procedures or the information to the information to the information to the information to the information or she is able to receive Follow-up procedures or the information to the informa	s include provisions to tten information to all adult he right to accept or refuse atment and, at the ulate an advance directive, ten description of the blement advance directives aw. litted to contract with other information but are still ensuring that the ection are met. al is incapacitated at the is unable to receive he whether or not he or she ince directive, the facility ctive information to the bresentative in accordance lieved of its obligation to in to the individual once he he such information. In ust be in place to provide individual directly at the lis not met as evidenced w, facility document review why facility document review why facility document review why facility staff failed of an advance directive for he survey sample, Resident life1 and #58	F 57	2.) Administrator/designee aud residents who admitted in the last 90 days to ensure that advance directives have been discussed with them. Any variances have been address immediately via care plan meetings, and discussions has been held and advance directived have been updated to reflect individual choices of all currer residents.  3.) The Administrator/designee in-serviced the Social Service Director and Nursing/Clinical leadership staff regarding the importance of discussing advocatives with residents at caplan meetings. The in-service includes, but not limited to, the importance of accurate advant directive orders for all resident completing the POST form, and the acceptable timeframe to begin discussing advance directives after admission to the facility.	ne ded de de de de de de de de de de de d	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING			l .	C
NAME OF P	ROVIDER OR SUPPLIER	100112	1 -1 -1 -1		TREET ADDRESS, CITY, STATE, ZIP CODE	04	/14/2022
EVERGRI	EEN HEALTH AND REHA	3		38	80 MILLWOOD AVENUE /INCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
	On the most recent MI quarterly assessment, reference date) of 3/15 interview for mental st correctly. On the prior admission assessment 12/13/2021, the reside the BIMS score indicate cognitively impaired for Further review of the devidence any document discussion regarding at The comprehensive cated documented in part, "Report to the comprehensive cated documented in part, "Report to the comprehensive cated advance directives/code." Interventions document and family on advance directives/code. An interview was conducted and services assistant responsibility It was for advance directive and precord, OSM #3 stated OSM #4] keeps a log of status is. When asked with the care plan meter to develop an advance during the care plan meter to develop an advance directive, OSM #3 state admission to determine directive, OSM #3 state admitted that is when we seed admission to determine directive, OSM #3 state admitted that is when we seed admission to determine directive, OSM #3 state admitted that is when we seed admission to determine directive, OSM #3 state admitted that is when we seed admission to determine directive, OSM #3 state admitted that is when we seed admission to determine directive, OSM #3 state admitted that is when we seed admission to determine directive, OSM #3 state admitted that is when we seed admission to determine directive.	with an ARD (assessment 5/2022, the BIMS (brief atus) was not coded MDS assessment, an t, with an ARD of ant scored a 13 out of 15 on the code atus of 15 on the code atus of 15 on the code at a co	F	578	I.) The Administrator/designee audit all newly admitted residents weekly for 6 weeks ensure that advance directive discussion has been initiated that the resident medical recreflects their individual choice. The Administrator/designee weet with social services dire and Nursing leadership weekl for 6 weeks to review all prevweeks admissions and ensure that advance directive orders completed and accurately refresident choices. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be tal. The Administrator/designee widentify 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 quarterly basis.  5.) Date of Compliance: 5/16/202	to es and ord es. will ctor y ious are ect	
8		e find out the code status					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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	-	495142	B. WING			04	4/14/2022
	ROVIDER OR SUPPLIER	В		380	EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE ICHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
	offer to provide them is develop an advance of only if the resident and don't offer the information knowledge. When as admitted and has an addess it go, OSM #3 statement when asked if she wo resident has or doesn' directive, OSM #3 statement into the recadmission does the fathow to initiate an advantated, no only if they are	livance directive, do you information on how to lirective, OSM #3 stated if or family request it, we stion to them to my ked when a resident is advance directive, where stated it is put into the record. It have an advance ed if the resident has one it cord. When asked on cility offer information on once directive, OSM #3 ask do we provide any reviewed the record for	F	578			
	asked the process for a directive for a new resistance directive and advance directive and when asked if a reside what you do, do you of developing an advance of the resident and/or factorovide them the information and an advance directive that asked should every resistent of advance of the discussion of advance of the discussion of advance directives of the discussion of advance discusses	A, the social worker. When obtaining an advance dent, OSM #4 stated on sks for a copy of the scans it into the chart. In the does not have one, fer information on a directive, OSM #4 stated mily is interested then we nation. When asked if it is a y do or do you wait for the pointiate, OSM #4 stated I on't who how to develop en we direct them. When ident have documentation wance directive, OSM #4 ad then it would be (durable do not resuscitate)				į	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		40.00					С
		495142	B. WING			04	/14/2022
	PROVIDER OR SUPPLIER EEN HEALTH AND REHA		,	3	STREET ADDRESS, CITY, STATE, ZIP CODE 180 MILLWOOD AVENUE NINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
*	stated that means the (cardiopulmonary resulthat is an advance directive it than that. OSM #4 state same. The residents who to see an advance disinformation was provide should that be done for stated, we could offer in the clinical record who documented, the residence asked if that include the discussion, OSM #4 stateds. When a new rethe one that requests the stated [name of admaths].	y don't want CPR iscitation). When asked if ective, OSM #4 stated no, is much more information ted the two are not the vere discussed that we did rective or evidence led on advance directives, ir all residents, OSM #4 ithat. A social worker's note as reviewed. The note ent will remain DNR, when e advance directive ated, no, it's only the code sident is admitted, are you the advance director - OSM inissions director - OSM	F	578			
	concerning the right to or surgical treatment are advance directive if he soPrior to or upon ac Social Services Director of the resident, his/her to her legal representation any written advance dirindicates that he or she advance directives, the assistance in establishing	pon admission, the d with written information refuse or accept medical and to formulate an or she chooses to do Imission of a resident, the r or designee will inquire family members and/or his ive, about the existence of ectivesIf the resident has not established facility staff will offer and advance directives. a. en the option to accept or and care will not be esisions. b. Nursing staff dical record the offer to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B, WING		*		C
NAME OF P	ROVIDER OR SUPPLIER	455142	B. WING.		TREET ADDRESS, CITY, STATE, ZIP CODE	04	/14/2022
	EEN HEALTH AND REHA	В		3	80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page	5	F:	578			
	ASM #4, the regional	staff member) #1, the 2, the director of nursing and nurse consultant, were ove concern on 4/13/2022					
	No further information	was provided prior to exit.			.#*		
	2. The facility staff faile documentation of a dis directives for Resident	scussion regarding advance					
	term memory problems	RD of 2/1/2022, the having both short and long					=
	Further review of the c evidence any documer discussion regarding a	ntation regarding a				i	
	documented in part, "F code." The "Interventio	re plan dated, 4/15/2020, ocus: Resident is a full ns" documented in part, family on choices in regard ode status."					*
1	birth] I give my children my daughter, [name of power of attorney to sp document was signed a	ented. "I [R47] [Date of , son [name of son] and					

			7			211122 64	0.000000
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		495142	B. WING			04	1/14/2022
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGI	REEN HEALTH AND REHA	В		3	80 MILLWOOD AVENUE		
				٧	VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	An interview was cond 12:30 p.m. with OSM social services assistate responsibility it was for advance directive and record, OSM #3 stated OSM #4] keeps a log of status is. When asked is, OSM #3 stated it's arequests for end of life documented that the reto develop an advance during the care plan more reviewed. When asked admission to determine directive, OSM #3 stated and if they have an advanced if there is no advanced if there is no advanced if the resident and don't offer the information when asked if she wouresident has or doesn't directive, OSM #3 stated is scanned into the reconstruction only if they are stated, no only if they a information. OSM #3 resident. OSM #3 stated directive on file.	ducted on 4/13/2022 at (other staff member) #3, the ant. When asked whose r obtaining a copy of the putting it in the clinical d [name of social worker - of what the resident's code what the advance directive a more detailed specific b. When asked where it is esident have been offered directive, OSM #3 stated leetings, the code status is differed they have an advance and when the resident is we find out the code status vance directive, When vance directive, do you information on how to rective, OSM #3 stated or family request it, we ion to them to my led when a resident is divance directive, where ted it is put into the record. Ill document if the have an advance led if the resident has one it ord. When asked on lility offer Information on ince directive, OSM #3 sk do we provide any leviewed the record for differed was no advance	F	578			
	- iz:ou p.m. with USM #4	4 the social worker When		- 1			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILDI		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING			C	
NAME OF B	ROVIDER OR SUPPLIER			_	PTDEET ADDRESS OFFI OTATE AND CODE	04	/14/2022
HANIC OF F	ROVIDER OR SOFFLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EEN HEALTH AND REHA	В			380 MILLWOOD AVENUE		
	****			1	WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	asked the process for directive for a new res admission the facility a advance directive and When asked if a reside what you do, do you o developing an advance if the resident and/or faprovide them the information to a directive the anadvance directive the asked should every resident and/or family don't initiate it. If they can advance directive the discussion of adstated if it was discuss documented. A DDNR form) was reviewed with stated that means they (cardiopulmonary resustant is an advance directive is than that. OSM #4 states ame. The residents who the see an advance directive is than that was provided should that be done for stated, we could offer the in the clinical record was documented, the reside when asked if that includiscussion, OSM #4 states status. When a new residence one that requests the one that requests the stated finame of admits. When shown the head of the stated finame of admits.	obtaining an advance ident, OSM #4 stated on asks for a copy of the scans it into the chart. ent does not have one, ffer information on e directive, OSM #4 stated amily is interested then we mation. When asked if it is ly do or do you walt for the to initiate, OSM #4 stated I don't who how to developmen we direct them. When sident have documentation vance directive, OSM #4 ed then it would be (durable do not resuscitate th OSM #4. OSM #4 don't want CPR scitation). When asked if ctive, OSM #4 stated no, much more information ed the two are not the ere discussed that we did ective or evidence and on advance directives, all residents, OSM #4 hat. A social worker's note as reviewed. The note on twill remain full code, des the advance directive dident is admitted, are you are advance director - OSM andwritten, notarized #4 was asked if that was	F	578			
		Tourself 1101					i

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/22/2022 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	9, WING				С
NAME OF F	PROVIDER OR SUPPLIER		2,		TREET ADDRESS, CITY, STATE, ZIP CODE	04	/14/2022
EVERGR	EEN HEALTH AND REHAI	B			80 MILLWOOD AVENUE IINCHESTER, VA 22601		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	Tommer Trom page		F	578			
	ASM #4, the regional a	taff member) #1, the d, the director of nursing and nurse consultant, were ove concern on 4/13/2022					
	No further Information	was provided prior to exit,					
	directives for Resident	cussion regarding advance #50.	22				
	quarterly assessment v reference date) of 02/0 scored 3 (three) out of interview for mental sta resident is severely imp making daily decisions.	15 on the BIMS (brief atus), Indicating the paired of cognition for				i	
	has established Do not	d in part, "Focus: Resident resuscitate (DNR) order. 120." Under "Interventions" Educate resident and pard to advance					
	Review of (R50's) clinic evidence documentation	al record failed to n of an advance directive.					:
:	social services assistan responsibility it was for o advance directive and p OSM #3 stated [name o	other staff member) #3, the t. When asked who's					

1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A, BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		495142	B. WING_		<del></del>	04	/14/2022
NAME OF P	ROVIDER OR SUPPLIER	ř.		ST	REET ADDRESS, CITY, STATE, ZIP CODE		-
CACOCOL	THE OF ALTH AND DELIA			38	0 MILLWOOD AVENUE		
EVERGRE	EEN HEALTH AND REHA	ь		W	INCHESTER, VA 22601		
(X4) ID	1	ATEMENT OF DEFICIENCIES	QI		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 578	Continued From page	9	F 5	578	50		
	When asked what the	advance directive is, OSM					<b> </b>
	#3 stated it's a more of	letailed specific requests for					li
		ed where it is documented	1	- 1			[
	that the resident have	been offered to develop an					
		M #3 stated during the care					1
' i		de status is reviewed. When					1
•	asked the process for						l
	-	an advance directive, OSM					
		sident is admitted that is					
}		code status and if they have		Ì			
		When asked if there is no					
		you offer to provide them					]
	information on how to						
Ì		ted only if the resident and	1	- i			
	* *	don't offer the information					
	resident is admitted ar	lge. When asked when a				i	
		it go, OSM #3 stated it is	1				
		hen asked if she would					
	•	nt has or doesn't have an		1			
		M #3 stated if the resident				1	
	has one it is scanned i		i			ļ	
	asked on admission de						
	information on how to	•					
	directive. OSM #3 state	ed, no only if they ask do		- 1			
		ation, OSM #3 reviewed				1	
		SM #3 stated there was no					
	advance directive on fi		ŀ				
	An interview was cond	usted on 4/42/2002 at					
		ucted on 4/13/2022 at 4, the social worker. When					
	•		i				
	asked the process for directive for a new resi	dent, OSM #4 stated on					,
	admission the facility a						
	admission the lacility a advance directive and						
	When asked if a reside						
	what do you do, do you		[				
		directive, OSM #4 stated					
		mily is interested then we					
	IONWIN WINDS		L				<b>I</b>

	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER.			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ı	495142					С
		495142	B. WING			04	/14/2022
NAME OF	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGE	REEN HEALTH AND REHA	8		:	380 MILLWOOD AVENUE		
	CONTINUENCE IN AND INCINA			1	WINCHESTER, VA 22601		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG		MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page	10	F	578			
	provide them the infor	mation. When asked if it is					
		ly do or do you wait for the					
		to initiate, OSM #4 stated I	1				
	don't initiate it. If they	don't know how to develop					1 1
	an advance directive t	hen we direct them. When					
		sident have documentation					i i
	of the discussion of ad	vance directive, OSM #4					] [
	stated if it was discuss	ed then it would be	}				[
		(durable do not resuscitate			İ		1
	form was reviewed wit	h OSM #4. OSM #4 stated					
	that means they don't						
	(cardiopulmonary resu	scitation). When asked if	ļ				
		ctive, OSM #4 stated no,					
		much more information					
	than that. OSM #4 stat		}				
		ere discussed that we did	ĺ				
	not see an advanced d						
	information was provid	ed on advance directives,					
	should that be done for						
		hat. A social worker's note					
	in the clinical record wa						
	documented, the reside	ent will remain DNR, when					i
	asked if that include the						
	discussion, OSM #4 sta	ated, no, it's only the code					
		sident is admitted, are you					
		ne advance directive, OSM					
	#4 stated [name of adm #5].	nissions director - OSM	!				
	An interview was condu	arted with OOM Art 4L-		ĺ		ſ	
	admissions director, on			l			
		nce directive is part of the					
	admission paperwork, (					- 1	
		nd stated it was not part of		-			İ
		rk. Upon admission to you		-			
i		dvance directive, OSM #5		- 1			
		as the social workers that					
	do that.	es the social workers that					
	www.ollida	i					
				- 1			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X	(X3) DATE SURVEY COMPLETED	
						С	
		495142	B, WING			04/14/2022	
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		STREET ADDRESS, CITY, STATE, 2 380 MILLWOOD AVENUE WINCHESTER, VA 22601	ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE	
F 578	On 04/13/2022 at app (administrative staff m and ASM # 2, director regional nurse consult the above findings.	11 roximately 5:00 p.m., ASM ember) # 1, administrator, of nursing and ASM # 4, ant, were made aware of was provided prior to exit	F	578			
	admission assessment reference date) of 03/2 scored 7 (seven) out of interview for mental staresident is severely improved in the comprehensive ca 03/26/2022 documente is a full code. Date Initial Timerventions it docum (CPR) Cardiopulmonar Date Initiated: 03/26/20 Review of (R111's) clinical evidence documentation and interview was conducted.	cussion regarding r Resident # 111.  DS (minimum data set), an exith an ARD (assessment 3/2022, the resident f 15 on the BIMS (brief atus), indicating the paired of cognition for re plan for (R111) dated d in part, "Focus: Resident fiated: 03/26/2022." Under mented in part, "Initiate y resuscitation as ordered. 22."  cal record failed to m of an advance directive.					
1 s r	12:30 p.m. with OSM (of social services assistant responsibility it was for advance directive and p OSM #3 stated [name of	ther staff member) #3, the					

	IENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		(X3) DATE SURVEY COMPLETED				
		495142	B. WING			l .	С
	2001/2000 000 011/201/000	493142	B. WING			04	/14/2022
NAME OF P	ROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRI	EEN HEALTH AND REHAI	В		:	380 MILLWOOD AVENUE		
				١	WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	Continued From page	12	F	578			
	When asked what the	advance directive is, OSM	'				
		etailed specific requests for			i		
		d where it is documented	ĺ				
		been offered to develop an					l f
		M #3 stated during the care					
		le status is reviewed. When					1
	asked the process for						
		an advance directive, OSM					
		sident is admitted that is					
İ		ode status and if they have	1				
	an advance directive.	When asked if there is no					
	advance directive, do	you offer to provide them			•		1
	information on how to	develop an advance	-				
		ed only if the resident and	1			İ	
	or family request it, we	don't offer the information					
}	to them to my knowled	ge. When asked when a					
į	resident is admitted an					,	
		t go, OSM #3 stated it is				i	i
İ	put into the record. Wi		1				j
1		nt has or doesn't have an					
		M #3 stated if the resident					
	has one it is scanned in						
	asked on admission do						
	Information on how to i						
		ed, no only if they ask do					
		ition. OSM #3 reviewed					İ
		OSM #3 stated there was					1
	no advance directive or	Title.				i	
	An interview was condu	inted on 4/42/2002 =+					
- 1							ļ
	asked the process for o	4, the social worker. When					
	directive for a new resid	ient, OSM #4 stated on				j	
	admission the facility as						
I .	admission the facility as advance directive and s						
	When asked if a reside						
	what do you do, do you			- 1			ĺ
		directive, OSM #4 stated					
		mily is interested then we					

PRINTED: 04/22/2022 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING \_ C 495142 R WING 04/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 578 | Continued From page 13 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O		(X3) DATE SURVEY COMPLETED	
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		495142	B. WING			04/14/2022
	PROVIDER OR SUPPLIER	fab	380	REET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE NCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIEI	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 578	(administrative staff and ASM # 2, direct regional nurse cons the above findings.	ge 14 pproximately 5:00 p.m., ASM member) # 1, administrator, for of nursing and ASM # 4, ultant, were made aware of on was provided prior to exit	F 578			
	On the most recent in quarterly assessment reference date) of 02 scored 3 (three) out interview for mental resident is severely in making daily decision. The comprehensive 04/23/2020 document has established Doir Date Initiated: 04/23/2020 dit documented in partifamily on choices in a directives/code status 04/23/2020.*  Review of (R61's) cline evidence documental	discussion regarding for Resident # 61.  MDS (minimum data set), a not with an ARD (assessment 2/04/2022, the resident of 15 on the BIMS (brief status), indicating the mpaired of cognition for ns.  care plan for (R61) dated not resuscitate (DNR) order. 2020." Under "Interventions" to resuscitate resident and regard to advance s. Date Initiated:				
:   5   F	12:30 p.m. with OSM social services assist esponsibility it was fo	ducted on 4/13/2022 at (other staff member) #3, the ant. When asked who's or obtaining a copy of the d put it in the clinical record				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		495142	B. WING			04	/14/2022
NAME OF P	PROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EEN HEALTH AND REHA	В	380 MILLWOOD AVENUE		80 MILLWOOD AVENUE		
E VEITOIT.			WINCHESTER, VA 2:		VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	OSM #3 stated [name keeps a log of what the When asked what the #3 stated it's a more dend of life. When asked that the resident have advance directive, OS plan meetings, the cocasked the process for determine if they have #3 stated when the resident when we find out the can advance directive, do information on how to directive, OSM #3 stated or family request it, we to them to my knowled resident is admitted an directive, where does it put into the record. Wildocument if the resider advance directive, OSM has one it is scanned in asked on admission do information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on the total control of the record for (R61). Of advance directive on fill the process for oddirective for a new residual advance directive and sadvance dir	e resident's code status is. advance directive Is, OSM letailed specific requests for ad where it is documented been offered to develop an M #3 stated during the care de status is reviewed. When a new admission to an advance directive, OSM sident is admitted that is code status and if they have When asked if there is no you offer to provide them develop an advance ed only if the resident and don't offer the information ge. When asked when a d has an advance t go, OSM #3 stated it is nen asked if she would nt has or doesn't have an W #3 stated if the resident nto the record. When less the facility offer initiate an advance ad, no only if they ask do ation. OSM #3 reviewed SM #3 stated there was no e.  Licted on 4/13/2022 at 4, the social worker. When lobtaining an advance dent, OSM #4 stated on sks for a copy of the scan it into the chart.	F	578			
	OSM #3 stated [name keeps a log of what the When asked what the #3 stated it's a more dend of life. When asked that the resident have advance directive, OS plan meetings, the cocasked the process for determine if they have #3 stated when the resident when we find out the can advance directive, do y information on how to directive, OSM #3 stated or family request it, we to them to my knowled resident is admitted an directive, where does it put into the record. Wild document if the resider advance directive, OSM has one it is scanned in asked on admission do information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state we provide any information on how to it directive, OSM #3 state when the resident information on how to it directive, OSM #3 state when the resident information on how to it directive, OSM #3 state when the resident information on how to it directive, OSM #3 state when the resident information on how to it directive, OSM #3 state when the resid	e resident's code status is. advance directive Is, OSM letailed specific requests for ad where it is documented been offered to develop an M #3 stated during the care de status is reviewed. When a new admission to an advance directive, OSM sident is admitted that is code status and if they have When asked if there is no you offer to provide them develop an advance ed only if the resident and don't offer the information ge. When asked when a dd has an advance t go, OSM #3 stated it is nen asked if she would nt has or doesn't have an W #3 stated if the resident nto the record. When less the facility offer initiate an advance ed, no only if they ask do ation. OSM #3 reviewed SM #3 stated there was no e.  Licted on 4/13/2022 at 4, the social worker. When lebtaining an advance dent, OSM #4 stated on sks for a copy of the scan it into the chart. Int does not have one,	F	578	DEFICIENCY)		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILO		E CONSTRUCTION		E SURVEY PLETED	
		495142	B, WING			1	C /14/2022	
NAME OF P	ROVIDER OR SUPPLIER			Τ,	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	THIZUZZ	
				1				
EVERGR	EEN HEALTH AND REHA	В		] 3	380 MILLWOOD AVENUE			
				\	WINCHESTER, VA 22601			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION			-
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI		DATE	
					DEFICIENCY)		1	ļ
								4
F 578	Continued From page	16	_	57D	l .			
			-	578	1			i
	developing an advance	e directive, OSM #4 stated						Į
İ	ir the resident and/or t	amily is interested then we			1			ł
		mation. When asked if it is						
	something you routine	ly do or do you wait for the					1	ı
	resident and/or family	to initiate, OSM #4 stated I						İ
	don't initiate it. If they	don't know how to develop						Į
1		hen we direct them. When					1	l
		sident have documentation			1			Ì
- 1	of the discussion of ad	vance directive, OSM #4						Į
,	stated if it was discuss	ed then it would be						ı
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	form was reviewed with	(durable do not resuscitate						Į
		h OSM #4. OSM #4 stated				!		Ì
ľ	that means they don't		i					l
	(cardiopulmonary resu	scitation). When asked if						Į
	that is an advance dire	ctive, OSM #4 stated no,	İ					۱
		much more information						ı
- 1	than that. OSM #4 stat	ed the two are not the						J
- 1	same. The residents w	ere discussed that we did	1	- 1			İ	Ì
	not see an advanced d			[				l
		ed on advance directives,		[				l
	should that be done for							ı
		hat. A social worker's note		ļ				l
- 1	in the clinical record wa	o soviewed. The sets						ı
								ı
	solved if thet institute the	ent will remain DNR, when				l		l
	asked if that include the			- 1				ı
[ +	discussion, OSM #4 sta	ated, no, it's only the code					i	
	status. When a new res	sident is admitted, are you		}				ĺ
1	the one that requests th	ne advance directive, OSM	1	- 1				ĺ
1	#4 stated [name of adm	nissions director - OSM		- 1			l	
	#5].							
						1		ĺ
- 17	An interview was condu	icted with OSM #5, the				ľ		
		4/13/2022 at 1:01 p.m.				1	ļ	
	When asked if the adva	nce directive is part of the				1		
	renon dones in the activity	nice unecove is part of the						
	admission paperwork, C	Join #5 reviewed the					]	
		nd stated it was not part of		ſ				
		rk. Upon admission to you		Ì		- 1		
	equest a copy of the ac	Ivance directive, OSM #5		ŀ			1	
S	stated she believed it wa	as the social workers that		1				

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OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING\_ 495142 04/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) F 578 Continued From page 17 F 578 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]

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION		DATE SURVEY COMPLETED	
		495142	B. WING			1	C /14/2022	
	ROVIDER OR SUPPLIER	В		380	REET ADDRESS, CITY, STATE, ZIP CODE D MILLWOOD AVENUE NCHESTER, VA 22601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	keeps a log of what the When asked what the #3 stated it's a more of end of life. When asked that the resident have advance directive, OS plan meetings, the cocasked the process for determine if they have #3 stated when the resident when we find out the can advance directive, do information on how to directive, OSM #3 state or family request it, we to them to my knowled resident is admitted and directive, where does it put into the record. Wild document if the resider advance directive, OSM has one it is scanned in asked on admission do information on how to it directive, OSM #3 state we provide any information on how to it direct	the resident's code status is, advance directive is, OSM detailed specific requests for an of the where it is documented been offered to develop an image of the status is reviewed. When a new admission to an advance directive, OSM sident is admitted that is so the status and if they have when asked if there is no expound offer to provide them develop an advance and don't offer the information in the status and if the would and has an advance at go, OSM #3 stated it is then asked if she would and has or doesn't have an in the stated if the resident and with the sor doesn't have an in the stated if they ask do ation. OSM #3 reviewed in the stated if they ask do ation. OSM #3 reviewed in the social worker. When in the stated in the social worker. When it is the social worker.	F	578				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. SUILDING CO	(X3) DATE SURVEY COMPLETED	
495142 B. WING	C 04/14/2022	
NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA 22601	04) 1412022	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
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, OSM #5 reviewed the admission paperwork. Upon admission to you request a copy of the advance directive, OSM #5		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B. WING			1	С
NAME OF P	ROVIDER OR SUPPLIER	770172	1		TREET ADDRESS, CITY, STATE, ZIP CODE	04/	14/2022
					80 MILLWOOD AVENUE		
EVERGRI	EEN HEALTH AND REHAI	В		WINCHESTER, VA 22601			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		0/6
PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	PREFIX TAG	x	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 578	Continued From page	20	F 5	578			
	On 04/13/2022 at app	roximately 5:00 p.m., ASM			F582 - Medicaid/Medicare		
		ember) # 1, administrator,	İ		Coverage/Liability Notice		
		of nursing and ASM #4,					
	the above findings.	ant, were made aware of			L.) Resident #106 is not currently	/ a	
	and above midnigs.				resident of Evergreen Health	and	
i		was provided prior to exit.		- 1	Rehab, therefore it is not		
[	F 582   Medicaid/Medicare Coverage/Liability Notice		F 5	82	appropriate to provide an AB	N at	
SS=D	CFR(s): 483.10(g)(17)	(18)(i)-(v)		- 1	this time. Evergreen Health a	nd	
	§483.10(g)(17) The fac	cility must			Rehab has identified that		
	(i) Inform each Medica	id-eligible resident, in			Medicare A residents are at r	isk	
		dmission to the nursing			from not receiving a SNFABN	31 <b>.</b>	
İ	facility and when the re Medicald of-	esident becomes eligible for			letter.		
1		rices that are included in					
		s under the State plan and		- 1	2.) Administrator/designee audit		-
	for which the resident r	may not be charged;			all skilled discharges since 4/1		1
	(B) Those other items				to ensure that the SNFABN w	J	
		hich the resident may be unt of charges for those	İ		issued appropriately. No other	r	
	services; and	and of ortal god for those			concerns were identified.		- [
	(ii) Inform each Medica	id-eligible resident when			3.) The Administrator/designee h	ias	ĺ
	changes are made to the			- 1	in-serviced Director of Therap	y	
	specified in §483,10(g) section.	(17)(i)(A) and (B) of this		-	Department and Social Servic	es	
					Director regarding SNFABN po	olicy	
1	§483.10(g)(18) The fac	ility must inform each	ĺ		and procedure. The in-service		
		e time of admission, and			includes, but not limited to, the	1	
		resident's stay, of services and of charges for those			facility to provide SNFABN		
		charges for services not			"information to the beneficial	.,	
[ -	covered under Medicar				so that s/he can decide wheth	·	
	facility's per diem rate.						
		overage are made to items			or not to get the care that ma	* 1	
	and services covered by Medicare and/or by the Medicaid State plan, the facility must provide				not be paid for by Medicare a		
	State of the plant, with	- worky most provide			assume financial responsibility	<i>[</i> ".	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B, WING		8		С
			ID	3 V	STREET ADDRESS, CITY, STATE, ZIP CODE  80 MILLWOOD AVENUE  VINCHESTER, VA 22601  PROPERTY SPLAN OF CORRECTION  (FACUL CORRECTION SHOULD BE		(X5) COMPLETION
TAG		SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE
	reasonably possible.  (ii) Where changes are items and services that facility must inform the 60 days prior to implet (iii) If a resident dies of transferred and does of facility must refund to representative, or estadeposit or charges alonger diem rate, for the cresided or reserved or facility, regardless of a discharge notice require (iv) The facility must reresident representative the resident within 30 date of discharge from (v) The terms of an adbehalf of an individual facility must not conflict these regulations.  This REQUIREMENT by:  Based on staff intervies and clinical record reviethe facility staff failed to facility advance benefic non-coverage (SNFAB beneficiary protection reviews, Resident #106's (R106 Medicare part A service)	the change as soon as is  a made to charges for other at the facility offers, the a resident in writing at least mentation of the change. It is hospitalized or is not return to the facility, the the resident, resident ate, as applicable, any eady paid, less the facility's days the resident actually retained a bed in the my minimum stay or rements. If the facility. It is any and all refunds due days from the resident's the facility. It is any and all refunds due days from the resident's the facility. It is not met as evidenced  aw, facility document review aw, it was determined that a provide skilled nursing clary notice of N) to one of three notification resident  b) last covered day of as was 11/7/21. The facility as SNFABN to Resident	F	582	<ul> <li>4.) The Administrator/designee we meet with therapy department manager and social services director weekly for 6 weeks to review all previous weeks SNF discharges from therapy servito ensure SNFABN was issued prior to discharge of services documentation of such is completed appropriately. Any issues identified will be addressed immediately by the Administrator/designee and appropriate actions will be ta The Administrator/designee widentify 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 lead quarterly basis.</li> <li>5.) Date of Compliance: 5/16/20</li> </ul>	ces and  ken. will	

PRINTED: 04/22/2022 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING\_ 495142 B. WING 04/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 582 Continued From page 22 F 582 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601	041,412022
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F 622 SS=E	with the opportunity to continue receiving the for by Medicare and a responsibility for the cappeal the decision of	o decide if they wish to e skilled that may not be paid assume financial care and of their right to f non-coverage."  was presented prior to exit, ge Requirements	F 58	Transfer and Discharge Requirements ) Residents #94 and #59 and returned from the emerger room or hospital and there	#10 ncy fore
	(A) The transfer or discresident's welfare and cannot be met in the file (B) The transfer or discresservices provided by the cause the resident's sufficiently so the resist services provided by the control of the case of the resident; (D) The safety of indivendangered due to the status of the resident; (D) The health of individual otherwise be endange; (E) The resident has file appropriate notice, to under Medicare or Medicare or Medicare or Medicare or Medicaid, resident refuses to pay resident who becomes admission to a facility,	requirements- ermit each resident to and not transfer or t from the facility unless- scharge is necessary for the the resident's needs acility; scharge is appropriate is health has improved dent no longer needs the he facility; iduals in the facility is a clinical or behavioral riduals in the facility would red; ailed, after reasonable and pay for (or to have paid dlcaid) a stay at the facility. If the resident does not paperwork for third party		no corrective action can be with the residents at this ti Residents #124 and #95 are longer residents of this fact and therefore no corrective action can be taken at this It is the policy of Evergreer Health and Rehab to ensur transfer and discharge requirements are met. All residents have the potentic be affected by the alleged deficient practice.  2.) Residents that transferred emergency room or admitting the hospital in the last 30 cand remain outside of this have been reviewed to entitle the required informat was sent with the resident variances have been corre	me. e no lity e time. e that al to to the eed to lays facility oure ion . Any

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID		ATEMENT OF DEFICIENCIES	ΩI	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		CROSS-REFERENCED TO THE APPROPRIA		DATE
					DEFICIENCY)		
F 622	Continued From page	24	=	622	3.) The Director of Nursing/desi	gnee	
1 022	or	24	-	022	has educated clinical nursing	-	
	(F) The facility ceases	to operate.			staff, including RN's and LPN		
	(ii) The facility may not transfer or discharge the				on documents required to be	•	
		eal is pending, pursuant to			· ·		
	§ 431.230 of this chap	r			sent with resident upon tran		
	-	ght to appeal a transfer or the facility pursuant to §	1		and discharge. The education		
	_	hapter, unless the failure to			included, but was not limited	to:	
		would endanger the health			sending contact information	of	
		nt or other individuals in the			the practitioner responsible	for	
		ust document the danger			the care of the resident, resi	dent	
	that failure to transfer	or discharge would pose.			representative information		
	§483.15(c)(2) Docume	entation.		17	including contact informatio	n,	
	When the facility trans				Advance Directive information		
		the circumstances specified			all special instructions or	,	1
	In paragraphs (c)(1)(i)				•		
	or discharge is docum	st ensure that the transfer		8	precautions for ongoing care		
		propriate information is		3	appropriate, comprehensive	care	
	communicated to the r			- 1	plan goals; goals with the		
	institution or provider.				resident upon discharge or		211
i		ne resident's medical record					*:
	must include:						
	(i) of this section.	ansfer per paragraph (c)(1)					
		graph (c)(1)(i)(A) of this					
		sident need(s) that cannot					
	be met, facility attempt						
		available at the receiving					
	facility to meet the nee	• •					
	(II) The documentation (2)(i) of this section mu	required by paragraph (c)					
		sician when transfer or					
		under paragraph (c) (1)			11		
	(A) or (B) of this section	n; and					
		ransfer or discharge is					
	necessary under parag	graph (c)(1)(i)(C) or (D) of					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	SURVEY
			A. BUILDI	ING .	<del></del>		
		495142	8. WING				C 14/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	EEN HEALTH AND REHAI	3			380 MILLWOOD AVENUE		
		·			WINCHESTER, VA 22601		
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	this section.  (iii) Information provide must include a minimu.  (A) Contact information responsible for the car.  (B) Resident represent contact information.  (C) Advance Directive.  (D) All special instruction on the compounding care, as approximation of the resident's consistent with §483.2 any other documentation as afe and effective transfer and facility document reflective transfer information was taff when five out of 4 sample were transferred Residents #94, #59, #1.  The facility staff failed to required information was taff when five out of 4 sample were transferred Residents #94, #59, #1.  The facility staff faile all required information hospital staff when Resto the hospital on 2/16/Per the facility's "Transincludes the following of the car.  (iii) Information provides and include a sample of the car.  (A) Contact information was approximately staff failed to require different information hospital staff when Resto the hospital on 2/16/Per the facility's "Transincludes the following of the car.	ed to the receiving provider am of the following: In of the practitioner re of the resident. Itative information including information for or precautions for opplate. In e plan goals; Ity information, including a discharge summary, I(c)(2) as applicable, and on, as applicable, to ensure insition of care. Is not met as evidenced  It was determined or provide evidence that all as provide do to the hospital; It was provided to the survey of the hospital; It was provided to the sident #95 and #10.  It was provided to the sident #94 was transferred to acute care transfers) V5	F	622	transfer and documentation of the medical record that the information was provided to resident upon transfer or discharge to the hospital.  The Director of Nursing/design will review all emergency room and hospital transfers for six weeks to ensure the comprehensive care plan summary and goals was sent the resident and documented the medical record. The Director of Nursing/designee will identary trends and/or patterns a additional education and trait will be provided on an ongoin basis. Findings will be discuss with the QAPI committee on least a quarterly basis.  (2.) Date of Compliance: 5/16/20	with d in ector ntify nd ining ng sed at	
	resuscitate)/advanced of transfer or discharge fo	rm, bed hold form, recent					Ì

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER	100142		r	TREET ADDRESS, CITY, STATE, ZIP CODE	04	/14/2022
EVERGRE	EEN HEALTH AND REHA	В		31	80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	history, MAR/TAR (merecord/treatment admiplan, immunization repertinent tests/diagnos notes/assessments are of these documents be Resident #94 was admighted to: metabolic eleobstructive pulmonary ulcer.  Resident #94's most reset) assessment, a sign assessment, with an a of 3/14/22, coded the reset of 15 on the BIMS (briestatus) score, indicating cognitively impaired. Trequiring extensive asstransfers, dressing, persupervision in eating/ II.  A review of the nursing 2/16/22 at 4:59 PM, resident with increased color and black tarry stractitioner notified and emergency room for extension was made for the evide information was provide 2/16/22 for Resident #50.	edication administration inistration record), care port, pertinent labs, stics, provider progress and belongings. No evidence eing provided was revealed.  Initted to the facility on included but were not encephalopathy, chronic disease and duodenal ecent MDS (minimum data enlificant change sessment reference date resident as scoring 03 out ef interview for mental gother resident was severely he resident was coded as sistance in bed mobility, resonal hygiene/bathing and occomotion.  In progress note dated evealed the following, a confusion, jaundice in cool noted. Nurse do order to send to the valuation."  In ately 2:45 PM a request ence of required ed to the hospital on the cool of	F	622			
	member) #1, the admir	nistrator and ASM #2, the ed, we do not have any					1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		•			
PREFIX (EACH DEFICIENCY				SHOULD B	ILD BE COMPI			
of kin. We realize that to fix.  On 4/13/2022 at 12:40 conducted with LPN (II LPN #4 stated we sent resident's demographic information with reside LPN #4 stated we also resuscitate), the medic and the completed elN from the computer. With copy of what is sent with hospital, LPN #4 stated.  An interview was conducted PM with ASM #2, the diasked the process for sithe hospital for resident based on our mock surfare revising our entire process, and we found process, and we found process. When asked checklist for residents to stated, Yes, the companion been in servicing the stated we need to do more well.	s information for this re a progress note on re a progress note on re a progress note on re a progress note on re a progress note on re a progress note on re an interview was reensed practical nurse) #4. d a profile sheet with the res and insurance rents for hospital transfers. TERACT transfer form renthen asked if there is a realth the resident to the red No, I do not think so.  TERACT transfer, When rending documentation to renth transfers, ASM #2 stated, rey 3/24/22-3/26/22, we reprocess regarding resident renth our old administrator renth to do some of the renth we had holes in the renth the fire was a transfer renth the some on the hospital, ASM #2 renth has one and we have reaff on using this form but renth or this.  ASM #1, the renth director of nursing and response in the renth director of nursing and renth director of nursing and renth director of nursing and	F	522	73)				

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		I INCLUSION TO A STATE OF THE S		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	Transfer and Discharg which reveals, "The transfer and Discharg which reveals, "The transfer and resident's need cannot medical record will conthe needed services a facility or location."  No further information  2. The facility staff falls all required information hospital staff when Reto the hospital on 2/4/2  Per the facility's "Transincludes the following (interventions to reduct care form, face sheet, resuscitate)/advanced transfer or discharge form.	pe* policy with no date, ansfer or discharge is dent's welfare and the to be met in the facility. The ntain documentation that re available at the receiving was provided prior to exit.  ed to provide evidence that in was provided to the sident #59 was transferred 22.  efer Check List" which documents: eINTERACT e acute care transfers) V5 DNR (do not directives, notice of orm, bed hold form, recent	F	522					
	of these documents be Resident #59 was adm 5/2/18 with diagnosis in limited to: congestive is mellitus, encephalopati pulmonary disease and Resident #59's most reset) assessment, a qua	nistration record), care ort, pertinent labs, tics, provider progress d belongings. No evidence ing provided was revealed.  itted to the facility on ncluded but were not neart failure, diabetes ny, chronic obstructive I atrial fibrillation.  cent MDS (minimum data interly assessment, with an date of 1/26/22, coded the							

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAB				STREET ADDRESS 380 MILLWOOD A WINCHESTER, V		,	1		
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	(brief interview for me the resident was seve The resident was code in bed mobility, transfe eating and limited assis hyglene/bathing.  A review of the nurse plated 2/4/22 at 8:37 A "Overnight nurse reporacting herself this more symptoms. 911 called On 4/12/22 at approximas made for the evide information was provide for Resident #59.  On 4/12/22 at 4:53 PM member) #1, the admindirector of nursing, statevidence of any of this resident. We only have Resident #59 for 2/4/2: realize that this is some On 4/13/2022 at 12:40 conducted with LPN (lift LPN #4 stated we sent resident's demographic information with resident LPN #4 stated we also	ntal status) score, indicating rely cognitively impaired, ed as requiring supervision ers, locomotion, dressing, istance for personal practitioner progress note M, which revealed, rts that resident is not ning. Stroke like for transport."  mately 2:45 PM a request ence of required led to the hospital on 2/4/22  If, ASM (administrative staff nistrator and ASM #2, the ted, we do not have any information for this e a progress note on 2 of the episode. We ething we need to fix.  PM, an interview was censed practical nurse) #4. If a profile sheet with the	F	322					
	and the completed eIN from the computer. Wh copy of what is sent wit hospital, LPN #4 stated	TERACT transfer form nen asked if there is a th the resident to the							

	(X3) DATE SURVEY COMPLETED		
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495142 B. WING 04	04/14/2022		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA 22601			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
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 3724/2-3726/22, 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, and we found we had holes in the process, and we found we had holes in 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 evel 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 falled to provide evidence that all required information was provided to the hospital staff when Resident #124 was transferred to the hospital on 17/20/22.]  Per the facility's "Transfer Check List" which			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF P	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
EVERGRI	EEN HEALTH AND REHAI	8			380 MILLWOOD AVENUE			
					WINCHESTER, VA 22601			
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F 622	Continued From page	31	F	322				
	includes the following	documents: eINTERACT						
		e acute care transfers) V5						
	care form, face sheet,							
	resuscitate)/advanced						1	
		orm, bed hold form, recent					[ [	
		dication administration						
	record/treatment admir	nistration record), care						
	plan, immunization rep		1					
	pertinent tests/diagnos	tics, provider progress						
	notes/assessments an	d belongings. No evidence						
	of these documents be	ing provided was revealed.	1				1 [	
	Desident #404							
i	Resident #124 was add 1/5/22 with diagnosis in							
	limited to: congestive i						1 1	
i		ective pulmonary disease						
	and acute respiratory fa						1	
	and addition respiratory in	and o.	1					
}	Resident #124's most r	ecent MDS (minimum	1					
	data set) assessment,					!	1	
	•	ssessment reference date	ĺ					
1	of 2/21/22, coded the re	esident as scoring 15 out						
	of 15 on the BIMS (brie	f interview for mental	Į					
	status) score, indicating							
		ne resident was coded as						
	requiring extensive ass							
	transfers, dressing, per	sonal hygiene/bathing and						
	independent for eating.							
	A continue of the constant	programa mate date d						
	A review of the nursing 1/20/22 at 9:46 AM, rev	. —		ļ				
		responsive at med pass.						
	911 called and paramed							
		nt's son notified at 0945."						
	On 4/13/22 at approxim	ately 12:30 PM a request						
	was made for the evide	•					1	
	nformation was provide						ļ	
	1/20/22 for Resident #1:	24.		- 1		ĺ		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFICATION NI IMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (	CODE	04/	14/2022	
EVERGREEN HEALTH AND REHAB			380 MILLWOOD AVENUE WINCHESTER, VA 22601	3000			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFE TAG		TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 622 Continued From page 3	2	F	522				
LPN #4 stated we send resident's demographics information with resident LPN #4 stated we also seems resuscitate), the medical and the completed elNT from the computer. Whe copy of what is sent with hospital, LPN #4 stated I with ASM #2, the direct asked the process for seems the hospital for resident to based on our mock surverare revising our entire process, and we found we process. When asked if checklist for residents to stated, Yes, the company been in servicing the staff we need to do more work.	ensed practical nurse) #4. a profile sheet with the s and insurance ts for hospital transfers. send any DNR (do not tion list, physician orders 'ERACT transfer form en asked if there is a the resident to the No, I do not think so.  Cted on 4/13/22 at 2:37 ector of nursing. When ending documentation to transfers, ASM #2 stated, ey 3/24/22-3/26/22, we rocess regarding resident then our old administrator to do some of the ve had holes in the there was a transfer the hospital, ASM #2 y has one and we have eff on using this form but k on this.  ASM #1, the the director of nursing and the consultant, were encern.  ASM (administrative staff trator and ASM #2, the d, we do not have any formation for this a progress note on						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			8E	(X5) COMPLETION DATE
F 622	that this is something According to the facility Transfer and Discharge which reveals, "The transcessary for the resident's need cannot medical record will contain the needed services a facility or location."	we need to fix. ty's "Facility Initiated ie" policy with no date, ansfer or discharge is	F	522			
	the receiving facility the practitioner responsible resident and the complete for a facility Initiated track (R95) on 3/1/2022.  On the most recent ME admission assessment reference date) of 2/14 assessed as being sevidaily decisions.  The progress notes for -"3/1/2022 16:43 (4:43 Text: This nurse was githe resident had pulled (gastrostomy tube). MF	rehensive care plan goals insfer of Resident #95  OS (minimum data set), an with an ARD (assessment /2022, the resident was erely impaired for making  R95 documented in part, p.m.) Nursing note. Note ven the information that out her gtube					

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495142	B. WING	B. WING		С	
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	04	4/14/2022
EVERGR	EEN HEALTH AND REHA	B			380 MILLWOOD AVENUE WINCHESTER, VA 22601		:
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From page	34	F	522			
	nurse "Why isn't mom nurse informed MPOA well she was progress Barium Swallow study signs or symptoms of a transfer. EMS (emerge	nt. MPOA (Son) ask this eating anything?" This that it would be up to how ing and what the Modified showed. Resident with no distress noted at time of ency medical services) th resident requiring total					
	assist from staff memb transfer from bed to gu stable). No signs or syl discomfort noted. Repo (emergency departmen	ers and EMS crew for imey. VSS (vital signs mptoms of pain or ort called to ED					
	The eInteract Transfer 3/1/2022 16:14 (4:14 p code status, responsible and reason for transfer	.m.) documented in part, le party contact information					
	the contact information	n of the information g facility or evidence of of the practitioner of the resident and the an goals for the facility					
22	via written list to ASM (a member) #1, the admini required transfer docum receiving facility for the 3/1/2022 for R95.	istrator for evidence of the entation provided to the facility-initiated transfer on					
	On 4/13/2022 at 12:40 p conducted with LPN (lice 4. LPN #4 stated that the with the residents demo information with resident	ensed practical nurse) # ney sent a profile sheet graphics and insurance					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	WULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
	495142 B. WING			C 04/14/2022				
NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601	Ē		I-1/2022	
(X4) ID PREFIX TAG				X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
	not resuscitate), the morders and the completers from the computer.  On 4/13/2022 at 2:37 of nursing, stated that 3/24/22-3/26/22 and we based on that. When transfer checklist for read they had been insolut they had been insolut they needed to do  On 4/13/2022 at 4:53 patted that they did not documents sent to the R95. ASM #2 stated that they did not documents sent to the R95. ASM #2 stated that something that they need they need to do with they	ey also sent any DNR (do nedication list, physician eted eInteract transfer form p.m., ASM #2, the director they had a mock survey were revising their process asked if there was a esidents to the hospital, e new company had one ervicing the staff on using it more work on this process.  D.m., ASM #1, and ASM #2 thave any evidence of the hospital on 3/1/2022 for hat they only had the they realized that this was seded to fix.	F	522				
	On the most recent MD	S (minimum data set), a						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER	455142	D. WING			04	/14/2022	
EVERGREEN HEALTH AND REHAL	В		:	STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION}	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
reference date) of 03/3 scored 15 out of 15 or for mental status), indi cognitively intact for mental status), indi cognitively intact for mental status), indi cognitively intact for mental status), indi cognitively intact for mental status). The facility's nurse pra 12/31/2022 documents call early this am (a.m. a.m.), that pt (patient) hallucinations, gave verements (emergency room) see a surprise and expected since not taking in much she [sic] continues to the (Emergency medical the refused to take her to each answered their question (sic) she is still seeing not present and lab (late co2 (carbon dioxide) lecame to work around 5 pt about what is going on there is 4 ppl stand to take a nap now and to see her. REFUSED (Review of the clinical redocumentation of information 12/31/2021  On 4/13/2022 at 12:40 conducted with LPN (lic) 4. LPN # 4 stated that with the resident's demonstration with resident LPN # 4 stated that the not resuscitate), the me	with an ARD (assessment 31/2022, the resident in the BIMS (brief Interview icating the resident is taking daily decisions.  Actitioner's note dated and in part, "Received phone in a part, "Received phone in a part, "Received phone in a part, "Received phone in a part, "Received phone in a part, "Received phone in a part, "Received phone in a part, "Received phone in a previous notes, this is not a did a decline soon with ptoth fluids or not eating well. It is a previous notes, this is not ad a decline soon with ptoth fluids or not eating well. It is a part in	F	622				

PRINTED: 04/22/2022 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING\_ 495142 B, WING 04/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID IĐ PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) F 622 Continued From page 37 F 622 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 623 Notice Regulrements Before Transfer/Discharge F 623 CFR(s): 483.15(c)(3)-(6)(8) SS=E §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

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:		IULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		495142	B. WING_			1	C /14/2022	
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAL SUMMARY STA	B XTEMENT OF DEFICIENCIES	Į įp	380	EET ADDRESS, CITY, STATE, ZIP CODE MILLWOOD AVENUE ICHESTER, VA 22601 PROVIDER'S PLAN OF CORRECTION			
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
	facility must send a corepresentative of the Cong-Term Care Omb (ii) Record the reasons discharge in the reside accordance with paragrand (iii) Include in the notice paragraph (c)(5) of this §483.15(c)(4) Timing of (i) Except as specified (c)(8) of this section, the discharge required under a tresident is transferred (ii) Notice must be made by the facility at resident is transferred (iii) Notice must be made before transfer or discit (A) The safety of indivible endangered under a this section; (B) The health of indivible endangered, under this section; (C) The resident's heal allow a more immediate under paragraph (c)(1) (D) An immediate transfequired by the resident under paragraph (c)(1) (E) A resident has not redays.	they understand. The appy of the notice to a office of the State addrag. It is section; the transfer or ent's medical record in graph (c)(2) of this section; the the items described in a section.  If the notice, in paragraphs (c)(4)(ii) and the notice of transfer or der this section must be least 30 days before the or discharged, the as soon as practicable the narge whenduals in the facility would be paragraph (c)(1)(i)(C) of the improves sufficiently to be transfer or discharge, (i)(B) of this section; the or discharge is the urgent medical needs, (i)(A) of this section; or desided in the facility for 30 of the notice. The written graph (c)(3) of this section ing:	F6		Residents #94 and #59 and a returned from the emergen room or hospital and theref no corrective action can be with the residents at this tin Residents #124 and #95 are longer residents of this facil and therefore no corrective action can be taken at this til is the policy of Evergreen Health and Rehab to ensure notice requirements before transfer/discharge are met. residents have the potential be affected by the alleged deficient practice.  2.) Residents that transferred the hospital in the last 30 dand remain outside of this factories have been reviewed to ensure that evidence of written notification of transfer was provided to the responsible and/or the ombudsman. Ar variances have been corrective.	#10 cy ore taken no ity ime. All I to co the ed to ays facility ure e party		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		(X3) DATE SURVEY COMPLETED		
	22					j ,	С
	;	495142	B. WING				14/2022
NAME OF P	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN HEALTH AND REHA	В	ļ	380	MILLWOOD AVENUE		
				WII	NCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
	(iii) The location to what transferred or discharge (iv) A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the form an hearing request; (v) The name, address telephone number of the Long-Term Care Ombo (vi) For nursing facility and developmental disabilities, the mailing telephone number of the protection and advice developmental disabilities of the Developmental and Bill of Rights Act of codified at 42 U.S.C. 1 (vii) For nursing facility disorder or related disabilished under the for Mentally III Individuals established under the for Mentally III Individuals \$483.15(c)(6) Changes If the information in the effecting the transfer or must update the recipies as practicable once the becomes available.	of transfer or discharge; sich the resident is ged; resident's appeal rights, ddress (mailing and email), r of the entity which s; and information on how rm and assistance in and submitting the appeal s (mailing and email) and the Office of the State and email address and the agency responsible for ocacy of individuals with these established under Part al Disabilities Assistance of 2000 (Pub. L. 106-402, 5001 et seq.); and residents with a mental abilities, the mailing and aphone number of the the protection and Advocacy als Act.  Is to the notice.  In notice changes prior to redischarge, the facility ents of the notice as soon a updated information	F	523	3.) The Administrator/designee educated social workers on notice requirements before transfer/discharge. The education included, but was limited to, notifying the resi or resident representative at the ombudsman of transfer/discharge, and documentation in the medic record that the information provided to the resident up transfer or discharge.  4.) The Administrator/designee review transfers/discharges six weeks to ensure that notification of transfer/discharges six weeks to the resident or resident representative and ombudsman, and that the notification was documented the medical record. The Administrator/designee will identify any trends and/or patterns and additional education and training will provided on an ongoing bas Findings will be discussed withe QAPI committee on at I quarterly basis.	s not ident and cal was on charge the cal in least a	
	§483.15(c)(8) Notice in	advance of facility closure			quarterly basis.  5.) Date of Compliance: 5/16/2	2022	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
:	İ	495142	B. WING				С
NAME OF F	ROVIDER OR SUPPLIER	453142	a. Willed			04	/14/2022
	EEN HEALTH AND REHA			38	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE /INCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	In the case of facility of the administrator of the written notification price to the State Survey Ag State Long-Term Care the facility, and the residual well as the plan for the relocation of the residual 483.70(I).  This REQUIREMENT by:  Based on staff intervie and facility document at the facility staff failed to documentation to the fresponsible party) and transfer to the hospital in the survey sample; in the survey sample; in the facility staff failed combudsman when Residual to the hospital on 2/16/ Resident #94 was adm 6/17/21 with diagnosis limited to: metabolic errobstructive pulmonary outcer.  Resident #94's most reset) assessment, a signal assessment, with an asof 3/14/22, coded the residual for the BIMS (briestatus) score, indicating status) score, indicating	closure, the individual who is a facility must provide or to the impending closure gency, the Office of the Ombudsman, residents of sident representatives, as a transfer and adequate ents, as required at § is not met as evidenced evidence written Resident or RP of ombudsman upon for five out of 45 residents Residents #94, #59, #124, and notify the RP and the dident #94 was transferred 22. Sitted to the facility on included but were not incephalopathy, chronic disease and duodenal cent MDS (minimum data sificant change sessment reference date esident as scoring 03 out	F	623			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE	(X3) DATE SURVEY COMPLETED		
		495142	B. WING			į .	C
	ROVIDER OR SUPPLIER			3	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601	04	/14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	1	ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROP DEFICIENCY)			(X5) COMPLETION DATE
	requiring extensive as transfers, dressing, posupervision in eating/ A review of the nursin 2/16/22 at 4:59 PM, re "Patient with increase color and black tarry se Practitioner notified ar emergency room for each of the evide documentation to the form of the evide documentation to the form of the evide documentation to the form of the evide documentation to the form of the evide documentation to the form of the evide documentation to the form of the evide documentation to the form of the evidence of the evidence of the evidence of the evidence of any of this resident. We only have Resident #94 for 2/16/2 of kin. We realize that to fix.  On 4/13/2022 at 12:40 conducted with LPN (Ii When asked what notif RP, LPN #4 stated we document it in the program of the evidence of the	esistance in bed mobility, ersonal hygiene/bathing and locomotion.  g progress note dated evealed the following, d confusion, jaundice in stool noted. Nurse and order to send to the evaluation."  mately 2:45 PM a request ence of written Resident or RP d ombudsman was 22 hospital transfer for  I, ASM (administrative staff nistrator and ASM #2, the ted, we do not have any information for this e a progress note on 22 that we notified the next this is something we need  PM, an interview was censed practical nurse) #4. fication is provided to the make a call to the RP and press notes. When asked if tion sent to the RP, LPN #4 written notice. When ombudsman, LPN #4 ng, I am not sure who	F	623			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		ECONSTRUCTION	(X3) DATE	SURVEY PLETED
			1,00,00	_			С
		495142	B. WING			04	/14/2022
NAME OF P	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EEN HEALTH AND REHA	В			80 MILLWOOD AVENUE		
				٧	VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	42	F	623			
	conducted with OSM	(other staff member) #3, the					
	social services assista	ant. When asked what					
		provided to the RP and the	}				
		stated, nursing verbally					
		is not anything in writing. ing in writing. I think the					
	previous administrator						
	ombudsman, but I am					52	
	On 4/13/22 at 5:00 PM						
	ASM #4, the regional r	the director of nursing and					
	informed of the above				SQ.		
	anomina of the above	CONCENT.	1				
-	According to the facility	y's "Facility Initiated					
1	Transfer and Discharg						
	which reveals, "Before						
		the facility will notify the					1
	transfer or discharge a	ent's representative of the					
		a language and manner					
		ce must be made as soon		İ			
	-	ransfer or discharge when		- 1			1
	the health of the individ	dual would be endangered.					
	The facility will send a					i	
	representative of the C						
ŀ	Long-Term Care Ombu	idsman."					
	No further information	was provided prior to exit.					
	O The Sealth4-202 W	4 4% - 44 - DD 1 - 1					
	-	d notify the RP and the sident #59 was transferred					
	ombudsman when Res to the hospital on 2/4/2						
ŀ	w nie neopitai vii £141&	fo:					
	Resident #59 was adm	itted to the facility on		1		i	
	5/2/18 with diagnosis ir						
	limited to: congestive I		}				
	mellitus, encephalopati	ny, chronic obstructive					

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495142	B. WING			!	C 14/2022	
NAME OF P	ROVIDER OR SUPPLIER		1	S	FREET ADDRESS, CITY, STATE, ZIP CODE		1-02-02-0	
EVERGRE	EN HEALTH AND REHAI	В			80 MILLWOOD AVENUE			
		·	,	W	INCHESTER, VA 22601			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 623	Continued From page	43	F	623				
	pulmonary disease an	d atrial fibrillation.						
	set) assessment, a quassessment reference resident as scoring 06 (brief interview for menthe resident was sever. The resident was code in bed mobility, transferenting and limited assing and limited assing the pattern of the nurse pattern of the nurse pattern of the nurse report of the	practitioner progress note M, which revealed, rts that resident is not ning. Stroke like for transport."						
	On 4/12/22 at approximate made for the evidence of the formula of							
	(responsible party) and							
	member) #1, the admir	e a progress note on 2 of the episode. We						
	When asked what notil RP, LPN #4 stated we	PM, an interview was censed practical nurse) #4. fication is provided to the make a call to the RP and press notes. When asked if						

1 1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		405440					С
		495142	B. WING			04	14/2022
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, STATE, ZIP COD 380 MILLWOOD AVENUE WINCHESTER, VA 22601	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	STEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	FIX (EACH CORRECTIVE ACTION	SHOULD B	_	(X5) COMPLETION DATE
	there is written notifical stated, we do not send asked who notifies the stated, that is not nurs does it.  On 4/13/22 at 1:28 PM conducted with OSM (social services assistal written notification is pombudsman, OSM #3 notifies the RP, there is Should there be anything previous administrator ombudsman, but I am An interview was cond PM with ASM #2, the dasked the process for sthe hospital for resident based on our mock surface revising our entire it to hospital transfers. Vieft, we found she used process, and we found process. When asked checklist for residents to stated, Yes, the compabeen in servicing the stive need to do more worth of the stated of t	ation sent to the RP, LPN #4 d written notice. When e ombudsman, LPN #4 ding, I am not sure who  I, an Interview was other staff member) #3, the nt. When asked what rovided to the RP and the stated, nursing verbally s not anything in writing. ng in writing. I think the used to notify the not sure.  Lucted on 4/13/22 at 2:37 Lirector of nursing. When sending documentation to t transfers, ASM #2 stated, vey 3/24/22-3/26/22, we process regarding resident When our old administrator I to do some of the we had holes in the lif there was a transfer to the hospital, ASM #2 ny has one and we have aff on using this form but ork on this.  ASM #1, the the director of nursing and urse consultant, were	F	623			
1.	According to the facility Transfer and Discharge which reveals, "Before a	policy with no date,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING				C
		495142	B. 111110			04/	14/2022
	ROVIDER OR SUPPLIER EEN HEALTH AND REHA	в		:	STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA. 22601		
				_	<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATÉMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	45	F	623	3		
	discharges a resident	, the facility will notify the					
		ent's representative of the				ŀ	
		and the reasons for the					-
		a language and manner					
		ice must be made as soon					
		transfer or discharge when					
		idual would be endangered.					
	representative of the	copy of the notice to a					
	Long-Term Care Omb				171		
	Long-Term Daic Onib	dusinan.					
	No further information	was provided prior to exit.					
	3. The facility staff faild ombudsman when Re transferred to the hosp						
	Resident #124 was ad	lmitted to the facility on					
	1/5/22 with diagnosis i	•				ļ	
	limited to: congestive						-
	mellitus, chronic obstru	uctive pulmonary disease					
	and acute respiratory t	fallure.					
3.5							
<b>I</b>		recent MDS (minimum					
	data set) assessment,						
	•	ssessment reference date resident as scoring 15 out					
	of 15 on the BIMS (brid						
		ig the resident was not			Vi		
		he resident was coded as					
		sistance in bed mobility,					
		rsonal hygiene/bathing and					
	independent for eating	) <b>.</b>	i				
	A review of the nursing						
	1/20/22 at 9:46 AM, re	vealed the following, inresponsive at med pass.					
	1 100100111 GHEVE DRI O	macpondito at mod pass.	1		1		ı

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING				C
NAME OF F	ROVIDER OR SUPPLIER		<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	<u>  04</u>	/14/2022
EVERGR	EEN HEALTH AND REHA	В	380 MILLWOOD AVENUE WINCHESTER, VA 22601				!
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	911 called and parame arrived at 0946. Reside the provided for the evide documentation to the large provided for the hospite that a notificate stated, we do not send asked who notifies the stated, that is not nurside the stated, that is not nurside stated, that is not nurside stated asked with OSM (conducted with OSM (conducted with OSM) (cond	edics dispatched and ent's son notified at 0945."  mately 12:30 PM a request ence of written Resident or RP d ombudsman was at transfer for Resident  PM, an interview was censed practical nurse) #4. fication is provided to the make a call to the RP and tress notes. When asked if tion sent to the RP, LPN #4 written notice. When ombudsman, LPN #4 ng, I am not sure who an interview was other staff member) #3, the last the stated, nursing verbally not anything in writing, and in writing. I think the used to notify the lot sure.  Interview was other staff member with the last to vide to the RP and the stated, nursing verbally not anything in writing. In writing we stated to notify the lot sure.  Interview was other staff member with the last to vide to the RP and the last to vide to vide to vide to vide to vide to vide to vide to	F	623			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495142	B. WING			1	С	
	ROVIDER OR SUPPLIER	L	. 1	31	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601	<u>  04</u>	/14/2022	
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	checklist for residents stated, Yes, the comp been in servicing the swe need to do more we need to do more we need to do more we need to do more we need to do more we need to do more we need to do more we need to do more we need to do not not not not not not not not not no	d we had holes in the d if there was a transfer to the hospital, ASM #2 any has one and we have staff on using this form but ork on this.  If, ASM #1, the If, the director of nursing and nurse consultant, were concern.  If, ASM (administrative staff inistrator and ASM #2, the ted, we do not have any information for this a a progress note on If a progress note on If a progress note on If a progress note on If a progress note on If a progress note on If a progress note on If a progress note on If a progress note on If a progress note on If a progress note on If a progress or If a	F	623				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		E SURVEY PLETED
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NAME OF B	ROVIDER OR SUPPLIER	700172				04	/14/2022
I MANUE OL E	NO VIDER OR SUFFLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN HEALTH AND REHAL	В		3	80 MILLWOOD AVENUE		
				٧	VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	Continued From page	48	F	623			
	4. The facility staff fail	led to evidence written					
		onsible party for a facility					
	initiated transfer of Re	sident #95 (R95) on		İ			
	3/1/2022.	•					
j			ŀ				
		DS (minimum data set), an		i			
İ	admission assessmen	t with an ARD (assessment					
	reference date) of 2/14	1/2022, the resident was					
		erely impaired for making					
İ	daily decisions.						ĺ
İ	The progress notes for	R95 documented in part,					
}	- "3/1/2022 16:43 (4:43	p.m.) Nursing note. Note	i				
		iven the information that					
	the resident had pulled		1				
	(gastrostomy tube). Mf	POA (medical power of					
	attorney) was notified o	of gtube being pulled out					
	and that resident would						
- 1	hospital for replacemen	nt. MPOA (Son) ask this				1	
	nurse "Why isn't mome	eating anything?" This				1	- 1
		that it would be up to how				İ	
	well sne was progressi Bodum Swallow study	ng and what the Modified showed. Resident with no					ĺ
		listress noted at time of		- 1			
	transfer. EMS (emerge					ľ	
		h resident requiring total					i
	assist from staff member			-			Į.
	transfer from bed to gui						ŀ
[ :	stable). No signs or syn	nptoms of pain or	i	ı			- 1
	discomfort noted. Repo						
	emergency departmen	t)."					
١,	Review of the clinical re	ecord for R95 failed to					
		n of written notification to					
	he responsible party fo						
	ransfer on 3/1/2022.	•					
1,	On 4/12/2022 40:40 -	5 m					
	via written list to ASM (a	a.m., a request was made administrative staff					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		495142	B. WING	_		04	/14/2022
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
EVEDODE	EEN HEALTH AND REHA	<b>D</b>		:	380 MILLWOOD AVENUE		
EACKOKE	EER NEXETT ARD RENA	5		۱	WINCHESTER, VA 22601		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	1D		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREF! TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION
F 623	Continued From page	49	F	623	3		
	member) #1, the adm	inistrator for evidence of					1
		the responsible party for the					
	facility-initiated transfe	er on 3/1/2022 for R95.					
	On 4/13/2022 at 12:40	p.m., an interview was					
		icensed practical nurse) #	ŀ				
		they did not send any					
i	written notification of t	ransfer to the responsible					
	party.						
	On 4/13/2022 at 1:28	p.m., an interview was					
		other staff member) #3,					
	social services assista						
		ey did not provide a written			~		
		sidents/responsible parties					
		at there was only a verbal					j .
	the hospital.	a resident was sent out to					
	On 4/13/2022 at 2:37 p	o.m., an interview was					
		2. ASM #2 stated that they				,	
		14/22-3/26/22 and were				İ	
i	revising their process t		ĺ		1		
		n notice to the responsible					
ĺ		hat they had found that the					
	•	revamped. ASM #2 stated					
		ress note in the chart was				İ	
	responsible party.	had of notification of the					
	0-440/0000	-1					
		ximately 5:00 p.m., ASM					
	#1, the administrator, F nursing and ASM #4, th	ASM #2, the director of					
	consultant were made						
		•					
	No further information v	was provided prior to exit.					
			<u> </u>		74		
				_			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B. WING			_	C	
	PROVIDER OR SUPPLIER EEN HEALTH AND REHA	В		3	STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601	1 0	4/14/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 623	Continued From page	50	F	623	3			
į	notification was provid	led to evidence written led for Resident # 10 and facility-initiated transfer on						
95	quarterly assessment reference date) of 03/3	the BIMS (brief interview cating the resident is						
:	call early this am (a.m. a.m.), that pt (patient) vhallucinations, gave ve	ed in part, "Received phone ) around 330 am 3:30						
	since not taking in muc she [sic] continues to to (Emergency medical te refused to take her to e							
	tho [sic] she is still seel not present and lab (lab co2 (carbon dioxide) lecame to work around 5 pt about what is going one there is 4 ppl standito take a nap now and t	ng ppl [sic] (people) that is poratory) confirmed critical yels. I [sic] immediately 30 am and spoke with this on, she continues to tell ng around me. she wants hanked me for coming in			A			
	documented, "Iv (intravi unsuccessful, when iv p	Note" dated 12/31/2021						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495142	B. WING				C /1 <b>4/2022</b>
	PROVIDER OR SUPPLIER	В		3	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601		14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	at the hospital and res called for transport. [N was notified of transfe Friend] was notified as Review of the clinical documentation of writt provided to (R10) and facility initiated transfe	sident agreed. 911 was lame of Nurse Practitioner] r and [Name of (R10's) s well.  record failed to evidence en notification was the ombudsman for the r on 12/31/2021.	F	323			
Œ	conducted with ASM (amember) # 2, director about the process for receiving facility for a 1 ASM # 2 stated that be 03/24/2022 through 03 their entire process. A	of nursing. When asked send documentation to the acility initiated transfer ased on mock survey on 1/26/2022, they are revising .SM # 2 stated that with the administrator, who used to s, they found they had are completely					
F 625 SS=E	(administrative staff me and ASM # 2, director regional nurse consultathe above findings.  No further information Notice of Bed Hold Pol CFR(s): 483.15(d)(1)(2)	• •	F 6	25	я		
	§483.15(d)(1) Notice b	efore transfer. Before a					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/22/2022 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A, BUILDING 495142 B. WING 04/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY F625- Notice of Bed Hold Policy F 625 Continued From page 52 F 625 Before/Upon Transfer 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 1.) Residents #94 and #59 returned specifies-(i) The duration of the state bed-hold policy, if from the emergency room or any, during which the resident is permitted to hospital and therefore no return and resume residence in the nursing corrective action can be taken facility: (ii) The reserve bed payment policy in the state with the residents at this time. plan, under § 447.40 of this chapter, if any; Residents #124 and #95 are no (iii) The nursing facility's policies regarding longer residents of this facility bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a and therefore no corrective resident to return: and action can be taken at this time. (iv) The information specified in paragraph (e)(1) It is the policy of Evergreen of this section. Health and Rehab to ensure that §483.15(d)(2) Bed-hold notice upon transfer. At bed hold policy requirements are the time of transfer of a resident for met. All residents have the hospitalization or therapeutic leave, a nursing potential to be affected by the facility must provide to the resident and the resident representative written notice which alleged deficient practice. specifies the duration of the bed-hold policy 2.) Residents that transferred to the described in paragraph (d)(1) of this section, emergency room or admitted to This REQUIREMENT is not met as evidenced bv: the hospital in the last 30 days Based on staff interview, clinical record review and remain outside of this facility and facility document review, it was determined have been reviewed to ensure the facility staff failed to evidence a bed hold was provided to four out of 45 residents in the survey that bed hold notice was sample who were transferred to the hospital; provided to the resident and/or Residents #94, #59, #124 and #95. the responsible party for each 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

facility-initiated transfer. Any variances have been corrected.

OFILE	TO TORTHIEDIORICE OF	MEDIONID OFICAIORO			<del></del>	CIAID IAC	7. 0930-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF D	ROVIDER OR SUPPLIER			6	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04/	14/2022
NAME OF F	MUNIDER OR SUFFLIER			ı	• • • • • • • •		
EVERGR	EEN HEALTH AND REHA	R		3	80 MILLWOOD AVENUE		
LVEROR			,	M	VINCHESTER, VA 22601		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG	ACCOUNT ON L	SC IDENTIFYING INFORMATION)	TAG	'	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ALE:	L L
		<del></del>	_				
F 625	Continued From page	53	F	625	3.) The Director of Nursing/des	ignee	
	hospital on 2/16/22.				has educated clinical nursing	3	
					staff, including RNs and LPN	s on	
	Resident #94 was adr	mitted to the facility on sincluded but were not			providing the bed hold polic	y to	
		encephalopathy, chronic			residents and/or resident		
	obstructive pulmonary	disease and duodenal			representatives upon each		
	ulcer.				facility-initiated transfer. Th	e	
1	Resident #94's most re	ecent MDS (minimum data			education included, but was	not	
	set) assessment, a sig	inificant change			limited to, providing the bed	hold	
		ssessment reference date			policy to residents and/or		
	of 3/14/22, coded the	resident as scoring 03 out	}				- 1
	of 15 on the BIMS (bri				resident representatives upo		
		g the resident was severely			facility-initiated transfer, an	d	
		he resident was coded as			documentation in the medic	:al	
		sistance in bed mobility, rsonal hygiene/bathing and			record that the information	was	
	supervision in eating/1				provided.		
ĺ	oupor violori in outing,	oodiiioiioii.			4.) The Director of Nursing/desi	ignee	
	A review of the nursing				· ·		
	2/16/22 at 4:59 PM, re		1	ĺ	will review all facility-initiate		
		l confusion, jaundice in			transfers for six weeks to en		
	color and black tarry st				that the bed hold policy was	.	
	Practitioner notified an emergency room for ev				provided to the resident or	j	
	emergency room for en	valuation.			resident representative and	that	
	On 4/13/2022 at 12:40	PM, an interview was	1		the this was documented in	1	1
		censed practical nurse) #4.			medical record. The Directo	- 1	
i	When asked who provi	des the bed hold, LPN #4		- i			
	stated it is not nursing.				Nursing/designee will identi	fy	
	On 4/13/22 at 1:28 PM	an intensiow was					
		other staff member) #3, the					
	social services assistar						İ
		OSM #3 stated, nursing					
T I	provides the bed hold.	no stated, natality					
	,						
		ucted on 4/13/22 at 2:37					
	PM WITH ASM #2, the di	irector of nursing. When	1				

NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA 22601  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA 22601  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)  PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETING TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE								С	
EVERGREEN HEALTH AND REHAB  380 MILLWOOD AVENUE WINCHESTER, VA 22601  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			495142	B. WING			04	/14/2022	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETIC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE			В		;	380 MILLWOOD AVENUE			
	PREFIX (EACH	DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	_	COMPLETION	
sked the process for sending documentation to the hospital for resident transfers. ASM #2 stated, based on our mock survey 3724/2-3728/22, 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. When asked if there was a transfer checkfist 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, "Proto initiated transfers, resident or resident 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."	asked the pithe hospital based on outare revising to hospital trileft, we found process, and process. We checklist for stated, Yes, been in service we need to complete the co	rocess for for resided in mock surplementation or residents the comparison of additional interest and interes	sending documentation to ant transfers, ASM #2 stated, arvey 3/24/22-3/26/22, we process regarding resident When our old administrator d to do some of the d we had holes in the diff there was a transfer to the hospital, ASM #2 any has one and we have staff on using this form but tork on this.  If ASM #2 stated, the bed hold policy. We so the bed hold for this had been and we reconcern.  If a SM #1, the the director of nursing and surse consultant, were concern.  If a SM #1 the director to initiated asident representatives will be a the facility's bed hold mission. A second written to the resident, and if a representative, at the e case of emergency	F	625	additional education and trai will be provided on an ongoir basis. Findings will be discuss with the QAPI committee on least a quarterly basis.	ning ng sed at		

-	OF DEFICIENCIES F CORRECTION	IDENTIFICATION MUNICIPAL			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B, WING				C /14/2022
	ROVIDER OR SUPPLIER	В		31	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601		11112022
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	10 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 625	Continued From page	: 55	F	625			
	bed hold information p when Resident #59 w hospital on 2/4/22.  Resident #59 was adr 5/2/18 with diagnosis limited to: congestive mellitus, encephalopa pulmonary disease an Resident #59's most n set) assessment, a qu assessment reference resident as scoring 06 (brief interview for mel the resident was seven The resident was code	nitted to the facility on included but were not heart failure, diabetes thy, chronic obstructive d atrial fibrillation.  ecent MDS (minimum data arterly assessment, with an edate of 1/26/22, coded the out of 15 on the BIMS ntal status) score, indicating rely cognitively impaired. ed as requiring supervision ors, locomotion, dressing,					
	A review of the nurse produced 2/4/22 at 8:37 A *Overnight nurse report acting herself this more symptoms. 911 called On 4/12/22 at approximate was made for the evident information for Resident On 4/13/2022 at 12:40 conducted with LPN (lift When asked who provistated it is not nursing.	rts that resident is not ning. Stroke like for transport."  mately 2:45 PM a request ence of required bed hold nt #59.  PM, an interview was censed practical nurse) #4. Ides the bed hold, LPN #4		and the second s		8	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
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		495142	B. WING			04	/14/2022
	ROVIDER OR SUPPLIER	В		;	STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	social services assistate provides the bed hold, provides the bed hold, provides the bed hold. An interview was concept with ASM #2, the casked the process for the hospital for resider based on our mock sure revising our entire to hospital transfers. We found she used process, and we found process. When asked checklist for residents stated, Yes, the comparts we need to do more we need to do more we need to do more we need to do more we hadmissions is to fill out do not have evidence or resident.  On 4/13/22 at 5:00 PM administrator, ASM #2, ASM #4, the regional materials and the facility no date, which reveals transfers, resident or r	ducted on 4/13/22 at 2:37 director of nursing. When sending documentation to at transfers, ASM #2 stated, rvey 3/24/22-3/26/22, we process regarding resident. When our old administrator did to do some of the li we had holes in the if there was a transfer to the hospital, ASM #2 any has one and we have taff on using this form but ork on this.  If ASM #2 stated, the bed hold policy. We of the bed hold for this  ASM #1, the the director of nursing and turse consultant, were concern.  If Bed Hold policy with the lift hold and return representatives will be the process the policy will be the process that we will be the process that we will be the process that we will be the process that we will be the process that we will be the process that we will be the process that we will be the process that we will be the process that we will be the process that the process th	F	625			
1	policy at the time of addination of addination of addination of a discourage of the provided in the provided i	mission. A second written to the resident, and if s representative, at the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495142	B. WING			04	/14/2022
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		3	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 625	Continued From page within 24 hours."  No further information	57 was provided prior to exit.	F	625	NA El		
	bed hold information p when Resident #124 w hospital on 1/20/22. Resident #124 was ad 1/5/22 with diagnosis i limited to: congestive	mitted to the facility on ncluded but were not heart failure, diabetes uctive pulmonary disease					
	Resident #124's most a data set) assessment, assessment, with an atof 2/21/22, coded their of 15 on the BIMS (briestatus) score, indicating cognitively impaired. The requiring extensive asstransfers, dressing, per independent for eating.  A review of the nursing 1/20/22 at 9:46 AM, reviewed and parameterized at 0946. Resided On 4/13/2022 at 12:40 conducted with LPN (lice	recent MDS (minimum a Medicare 5 day ssessment reference date esident as scoring 15 out of interview for mental g the resident was not he resident was coded as sistance in bed mobility, reconal hygiene/bathing and  progress note dated vealed the following, hresponsive at med pass. dics dispatched and ant's son notified at 0945."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495142	B. WING		_		С	
	ROVIDER OR SUPPLIER			3	STREET ADDRESS, CITY, STATE, ZIP CODE 360 MILLWOOD AVENUE WINCHESTER, VA 22601	1 04	4/14/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH FOR CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)			(X5) COMPLETION DATE	
	On 4/13/22 at 1:28 PM conducted with OSM (social services assistate provides the bed hold, provides the bed hold.  An interview was conditioned by with ASM #2, the casked the process for the hospital for resider based on our mock sure revising our entire to hospital transfers. We found she used process, and we found process. When asked checklist for residents stated, Yes, the compassioned been in servicing the since we need to do more we need to do more we conditioned of the above of the conditioned of the above of the conditioned of the facility to date, which reveals, transfers, resident or reside	A, an interview was (other staff member) #3, the int. When asked who OSM #3 stated, nursing fucted on 4/13/22 at 2:37 director of nursing. When sending documentation to at transfers, ASM #2 stated, revey 3/24/22-3/26/22, we process regarding resident When our old administrator of to do some of the we had holes in the if there was a transfer to the hospital, ASM #2 my has one and we have taff on using this form but bork on this.  ASM #2 stated, the bed hold policy. We of the bed hold for this  ASM #1, the the director of nursing and urse consultant, were concern.	F	625				
t t	policy. Residents and reprovided information on policy at the time of administration of administration of administration of the provided to t	the facility's bed hold				1		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		E SURVEY IPLETED
		4054.0				С
		495142	B. WING		04	/14/2022
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		STREET ADDRESS, CITY, STATE, ZIP C 380 MILLWOOD AVENUE WINCHESTER, VA 22601	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREF TAG		MON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	applicable the residentime of transfer or in the within 24 hours."  No further information  4. The facility staff fail notice provided to the for a facility initiated track (R95) on 3/1/2022.  On the most recent MI admission assessment reference date) of 2/14 assessed as being seviced daily decisions.  The progress notes for - "3/1/2022 16:43 (4:43) Text: This nurse was gifted the resident had pulled (gastrostomy tube). Mi attorney) was notified of and that resident would hospital for replacementarse "Why isn't mome nurse informed MPOA well she was progression before the staff of transfer. EMS (emerge)	t's representative, at the ne case of emergency  was provided prior to exit.  led to evidence bed hold resident/responsible party ansfer of Resident #95  DS (minimum data set), an at with an ARD (assessment bl/2022, the resident was verely impaired for making are persent impaired for making are persent to the information that a out her glube people out the people of glube being pulled out the people of th	F	625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
							С
		495142	B. WING			04/	14/2022
	ROVIDER OR SUPPLIER	В		STREET ADDRESS, CITY, ST 380 MILLWOOD AVENUE WINCHESTER, VA 2260	• • • • •		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 625	Continued From page		F	525			
**	documentation of bed	record failed to evidence hold notice provided to the earty for the facility initiated or R95.					
	via written list to ASM member) #1, the admi bed hold notice provid	nistrator for evidence of ed to the arty for the facility-initiated					
	conducted with LPN (I 4. LPN #4 stated that hold notice but they ca the next day if the resi	p.m., an interview was icensed practical nurse) # they did not provide a bed alled the responsible party dent was admitted to inform bed hold to see if they					
	they had a mock surver were revising their pro- #2 stated that the previous of the process were holes in the procest were holes in the procest they were revamping to 4/13/2022 at 2:45 p.m. previously admissions policy and the administ responsible party and the policy and the this was something that this was something the provious of the process of t	cess based on that. ASM fous administrator used to so they found that there ess. ASM #2 stated that the bed hold process. On ASM #2 stated that would fill out the bed hold trator would then notify the					
	On 4/13/2022 at approx #1, the administrator, A						

•	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
i		495142	B. WING_			Ι,	C )4/14/2022
NAME OF P	ROVIDER OR SUPPLIER	<u> </u>	<del></del>	S	STREET ADDRESS, CITY, STATE, ZIP CODE		1411412022
EVERGR	EEN HEALTH AND REHA	В			380 MILLWOOD AVENUE WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>(</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
· · · · · · · · · · · · · · · · · · ·				$\dashv$	F641/12 VAC 5-371-250	A)(12)-	
F 625	Continued From page	61	F6	25	Accuracy of Assessment	•	
	nursing and ASM #4, consultant were made	the regional nurse aware of the findings.			1.) The complete MDS was r		
		, and the second			for residents #31 and #13		s l
	1	was provided prior to exit.		ľ	and Section C were comp		
F 641	Accuracy of Assessme	ents	F6	41	for both residents to ensi	re that	:
SS=D	CFR(s): 483,20(g)				the MDS accurately reflec	ts the	ŀ
	§483,20(g) Accuracy	of Assessments.			resident's status and that	the	
	The assessment must	accurately reflect the			MDS was properly comple	eted.	2
	resident's status.	is not met as evidenced			Evergreen Heath and Reh		
	by:	is not met as evidenced			identified that all resident		
	Based on staff interview	ew and clinical record			risk from this alleged defi		· [
		ned that the facility staff			practice.		1
		mplete MDS (minimum		- 1	2.) The Director of Nursing/d	ncianno	
	data set) for 2 of 45 re sample, Resident #31	<del>-</del>			has performed an MDS au	nir -t :2iRii66	
	Sample, Resident no		İ		BIMS and Section C for res	ait of	
	The findings include:			-		idents	
	4 000 C DIA 4 07 C 10				with a completed MDS		j
ĺ		ed to complete the BIMS ntal status) assessment for			assessment for the 30 day		
		quarterly MDS assessment			ensure that the MDS accur		
	with an ARD (assessm				reflects the resident's stat		
	1/24/2022.	i	{		was properly completed. A		
ł	Castian B of B34's sug	arterly MDS assessment			variances have been addre		
	•	022 coded the resident as	ĺ		and the MDS has been upo	ated.	
		ction C0100 documented			3.) The Director of Nursing/de	signee	
		should be conducted. All			has in-serviced MDS staff		
		d to the BIMS assessment		- 1	regarding accurate and tim	ely	
	score were coded as n	) and the BIMS summary			MDS completion. The in-se		
					includes, but no limited to,		
	On 4/13/2022 at 1:07 p				importance of completing t		
		other staff member) #4, the			BIMS and Section C and the		
i i		es. OSM #4 stated that should be attempted on all			importance of the MDS		
	THE DHAID ESSESSIBILE	enould be attempted on all			accurately reflecting the		
ORM CMS-2567	(02-99) Previous Versions Obsok	ste Event ID: JV0T11	<del></del>	Facil			t Page 62 of 109
					resident a status,	100	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLÍA IDENTIFICATION NUMBER:			3	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY		
			_		,	c			
		495142	B. WING				14/2022		
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE				
EVEDOD	CENTICAL THE AND DELLA	-		3	80 MILLWOOD AVENUE				
EVERGRI	EEN HEALTH AND REHA	В		ļν	VINCHESTER, VA 22601				
(X4) ID			ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG			PREF TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		COMPLETION DATE		
F 641	Continued From page	62	1 _	641	4.) The Director of Nursing/desig	nee			
	residents. OSM #4 st		[	041	will conduct an audit of 25% of				
		15, being cognitively intact.			resident's MDS weekly for fou	-			
		quarterly MDS with the			1				
		stated that they did not			weeks to ensure that BIMS an	id			
		as not completed. OSM #4			Section C are completed and				
		review the record and	i		accurate. The Director of				
	determine why the ass	sessment was not			Nursing/designee will also au	dit			
:	completed.				the initial MDS of any new		]		
	On 4/43/2022 at 4:22	- OCH #4 -4-4-4 #-4			· ·		- 1		
	On 4/13/2022 at 1:22 p.m., OSM #4 stated that they had reviewed R31's record and it appeared				admissions daily for six weeks	1	i		
		n signed off when the ARD			ensure accuracy and completi		- 1		
l		IMS assessment being			of BIMS and Section C. Any issuidentified will be addressed				
	completed. OSM #4 s						ĺ		
	assessment should ha				immediately by the Director	of			
		·			Nursing/designee and		- 1		
	On 4/14/2022 at 8:18 a						ŀ		
i		gistered nurse) #3, the			appropriate corrective action	- 1			
		en asked for a policy on			will be taken. The Director o	f			
		of the MDS, RN #3 stated			Nursing/designee will identif	fy			
		follow the RAI (resident			any trends and/or patters ar		l		
	assessment Instrumen	t) manual.			provide education and traini	- 1			
	The CMS (centers for	medicaid and medicare			•	E			
		documents the following:			staff on an ongoing basis.	. [			
		terview for Mental Status	ì		Findings will be discussed wi	th			
	Be Conducted?		=	i	the QAPI committee on at le	ast a			
	Item Rationale			ļ	quarterly basis.				
	Health-related Quality				5.) Date of Compliance: 5/16/20	122			
	·Most residents are ab	•			3.7 Date of Compliance, 3/10/20	722			
	Interview for Mental St	, ,							
		test is more accurate and		İ					
	reliable than observation					Į			
	cognitive performance.								
	<ul> <li>Without an attempted intension, a resident mi</li> </ul>	ght be mislabeled based							
		gnt be misiabeled based ce or assumed diagnosis				ĺ			
	<ul> <li>Code 1, yes: If the interview should be conducted because the resident is at least sometimes</li> </ul>								

PRINTED: 04/22/2022

FORM APPROVED

	AND DIAN OF CORRECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495142	B. WING			C 04/14/2022	
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI			3	STREET ADDRESS, CITY, STATE, ZIP CODE  80 MILLWOOD AVENUE  VINCHESTER, VA 22601	U4	14/2022
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
	method Coding Tips Attempt to conduct the residents. This intervie took-back period of the Date (ARD)"  The facility policy, "ME Submission Timeframe "1. The assessment responsible for ensuring assessments are submissionally system in accordance state guidelines. 2. The and submission of assessment requirements publications and submission of assessment Instrumer. On 4/13/2022 at approwers and ASM #4, the consultant were made. No further information with a set of assessment, with a reference date) of 3/15 (R110).  On the most recent MC.	e interview with ALL ew is conducted during the e Assessment Reference  OS Completion and es" documented in part, coordinator or designee is ng that resident nitted to CMS's QIES on and Processing (ASAP) with current federal and imeframes for completion essments is based on the published in the Resident at Manual"  Eximately 5:00 p.m., ASM ASM #2, the director of the regional nurse aware of the findings.  Was presented prior to exit.  In to complete Section C - erly MDS (minimum data an ARD (assessment 1/2022 for Resident #110  OS (minimum data set) a with an ARD (assessment 1/2022, the BIMS (brief ttus) was not coded	F	641			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		405445				С	
		495142	B. WING			04	/14/2022
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		3	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		1	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
	the BIMS score Indica cognitively impaired for cognitively impaired for the quarterly MDS as 3/15/2022, in Section or resident interview was Under the resident intercoded as "not assesse for the BIMS. In Section Interview be Conducted documented.  An interview was condimember) #4, the social responsible for completive assessment, on 4/14/2 was asked to review the with an ARD of 3/15/20 reviewing it, OSM #4 standard was asked to review the with an ARD of 3/15/20 reviewing it, OSM #4 standard was asked it as that. OSM looking in the progress writes when she does it assessments, to see if that would tell her why did. After reviewing the stated, "There is no not do write a note."	ent scored a 13 out of 15 on the tresident not or making daily decisions.  Sessment with an ARD of C - Cognitive patterns, the coded to be completed. erview questions, it was not for all of the questions on C0600 - Should the Staff d, "not assessed" was  sucted with OSM (other staff I worker, who is ting Section C of the MDS 022 at 8:18 a.m. OSM #4 are above MDS assessment 022, Section C. After tated, "I did that, I don't tassessed. I know how to not refuses." When asked we being coded as "not ated, "I don't know why I M #4 stated she was notes, that she normally	F	541			
	8:18 a.m. When asked Section C of the MDS, I	for a policy on completing RN #3 stated there is no tAI (resident assessment					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B. WING	R WING		C 04/14/2022	
NAME OF F	ROVIDER OR SUPPLIER	700178	1				
NAME OF F	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRI	EEN HEALTH AND REHAI	3	1				
	1			44	NCHESTER, VA 22601		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(XS) COMPLETION DATE
F 641	Continued From page	65	Fé	341	F656/12 VAC 5-371-250/ 12 V	VAC	
	Instrument) manual.	-	'	7'	5-371-250 (G)-		
	instrument) manual.			- 1	Develop/Implement		
	ASM (administrative s	taff member) #1. the			Comprehensive Care Plan	j	
		the director of nursing and			Comprehensive		
	ASM #4, the regional:	nurse consultant, were			1.) Resident #57 was assessed by	y	
		ove concern on 4/13/2022	}		nursing staff and their medic		
	at 5:15 p.m.	İ		records were reviewed. The		ĺ	
	No further information	was provided prior to exit.			resident's care plans have be	en	
F 656			F 6	56		`''	1
SS≃D			"0.		updated to reflect a current		
00-5					individualized plan of care.	. 1	i
	§483.21(b) Comprehe				Evergreen Heath and Rehab		
	§483.21(b)(1) The faci		-		identified that all residents a	re at	
		ensive person-centered		1	risk from this alleged deficie	nt	
	•	dent, consistent with the			practice.		i
	resident rights set forth §483.10(c)(3), that incl		-		2.) The Director of Nursing/desi	anoa	•
		nes to meet a resident's					
	-	mental and psychosocial	}	- 1	will perform an audit of resid		i
ľ		d in the comprehensive			who had a fall over the last 3	1	- 1
		orehensive care plan must			days to ensure that the Care	(	
	describe the following				plans have been updated to		
		e to be furnished to attain			ensure individualized needs		
	or maintain the resider	rs nignest practicable sychosocial well-being as					
		1, §483.25 or §483.40; and			addressed appropriately. A		
		ould otherwise be required			process has been developed		-
		5 or §483.40 but are not			implemented to identify res	ident	i
		ident's exercise of rights			care needs in the daily	1	0.0
	under §483.10, includir				interdisciplinary team meet	ing,	i
	treatment under §483.				and to update the care plan		
	(iii) Any specialized ser	•			reflect the needs identified.		
	rehabilitative services t provide as a result of P						
		ASARK facility disagrees with the			3.) The Director of Nursing/des	ignee	
	findings of the PASARF				has in-serviced nursing		
	rationale in the residen				leadership and interdiscipling	nary	
				_	<u> </u>		

						CIAID 146	<del>,, 0000-0</del> 00 i
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		406440	D MILLO	D. 144112			С
		495142	B. WING_			04/	14/2022
NAME OF P	ROVIDER OR SUPPLIER			នា	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EN HEALTH AND REHA	3			80 MILLWOOD AVENUE		
				W	INCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE
					team members regarding car	e	
F 656	Continued From page	66	Fe	556	plan updates. The in-service	_	
	(iv)In consultation with		}	1	includes, but no limited to, th		
	resident's representati				importance of care plan revie		
	(A) The resident's goa desired outcomes.	is for admission and			-		
j		erence and potential for	}		and updates with any change	s tor	
	future discharge. Facil	ities must document			each resident and care plans		
l	whether the resident's				being reflective of individuali	zed	
j		sed and any referrals to			care needs.		
	entities, for this purpos	and/or other appropriate	İ		4.) The Director of Nursing/design	nee	
		the comprehensive care			will conduct an audit, of resid	ents	
	plan, as appropriate, ir				with a fall, weekly for four we	eks	
		in paragraph (c) of this		-	to ensure that interventions a	re	
İ	section. This REOUREMENT	is not met as evidenced			appropriate and reflect the		
	by:	13 Hot met as evidenced			individual needs of each resid	lent	l
	•	, staff interview, facility			in their care plan. The Directo		
1		clinical record review, it			Nursing/designee will also au		
	was determined the fac-					uit	
	of 45 residents in the s	hensive care plan for one			the care plans of any new	.	
	0, 10 1001001110 111 010 0	arroy sumple, #51.	•		admissions weekly for six wee		
	The findings include:				to ensure that interventions a	re	
				ì	appropriate and reflect the		
	The facility staff failed t		i		individual needs of each resid	ent.	
	comprehensive care pl both sides of the bed for				Any issues identified will be		
İ	Dotti Sides of the bed it	n Nesident #37.			addressed immediately by the	.	
	On the most recent MD	S (Minimum Data Set), a			Director of Nursing/designee		
		an ARD (Assessment			Ç. Ş		
		/22, Resident #57 scored			appropriate actions will be tal	4	- 1
	a 8 out of 15 on the BIM				to update the resident care pl	ans.	i
	mental status), indicatir					ł	
	severely cognitively imp						
	decisions. The resident						
	dependent on staff for a (ADL).	cuvides of daily living					
[ '	(/ WL).					}	
	On 4/12/22 at 12:55 PN	1, and on 4/13/22 at 4:00	<b></b>				
ORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JV0T11				Facili	lty ID: VA0218 If continual	ion sheet F	age 67 of 109

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT		(X3) DATE SURVEY COMPLETED			
			A. BUILDING			С	
		495142	B. WING_	B. WING			14/2022
NAME OF F	PROVIDER OR SUPPLIER		Ī		TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	EEN HEALTH AND REHAI	3			80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(VA) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	al		PROVIDER'S PLAN OF CORRECTION		OVE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE			(XS) COMPLETION DATE
F 656	Continued From page	67	F6	156	The Director of Nursing/desi	-	
	]	s observed in bed. There	' '		will identify any trends and/o		
	was a fall mat on the o	door side of the bed	}		patters and provide education	'n	
		There was no fall mat on		i	and training to staff on an		
	the other side of the b	ea.			ongoing basis. Findings will b	e	
	A review of the compre	ehensive care plan			discussed with the QAPI		
		/17/21 for "Resident is at			committee on at least a quai	rterly	
		weakness and unsteady		ŀ	basis.		
	gait." This care plan included the intervention, dated 12/21/21 for "Floor mat to both sides of bed."			i	5.) Date of Compliance: 5/16/20	)22	
	-	3 (Licensed Practical f a resident was care n both sides of the bed and was the care plan being					:
	This policy documented develop and implement person-centered care placed includes measurable of to meet a resident's me	n-Centered" was reviewed. d, "2. The facility will t a comprehensive blan for each resident, that bjectives and timeframes edical, nursing, and mental s as identified throughout sident Assessment					
	with ASM #1 (Administance) Administrator, and ASM Nursing were made aw	are of the findings. No provided by the end of the	F 6	57			

]	COMPLETED
495142 B. WING	С
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	04/14/2022
EVERGREEN HEALTH AND REHAB  380 MILLWOOD AVENUE WINCHESTER, VA 22601	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657 SS=E CRR(s): 483.21(b)(2)(i)-(iii)  §483.21(b)(2) A 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 their resident's representative(s). An explanation must be included in a resident's medical record if the participation of the 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. (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  F 657  F 6	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 657	Continued From page The findings include:  1. Facility staff failed a comprehensive care page Resident #57.  On the most recent M 5-day assessment, with Reference Date) of 2/3 a 8 out of 15 on the 81 mental status), indicat severely cognitively imdecisions. The resided dependent on staff for (ADL).  A review of the clinical following:  A nurse's note dated 1 *1420 (2:40 PM)-at this was yelling out 'HELP' sounding, staff ran to redorway staff observed had fallen from w/c (wiresident what happened)	to review and revise the plan after a fall on 1/8/22, for DS (Minimum Data Set), a sth an ARD (Assessment B/22, Resident #57 scored MS (brief interview for ing the resident was apaired for making daily not was coded as being activities of daily living record revealed the land resident's roommate and resident's roommate and resident's alarms oom when approached diresident on floor, resident meel chair), when asked and [Resident #57] states *I	F 657	3.) The Director of Nursing/designee has inserviced nursing leadership and interdisciplinary team members regarding care plant updates. The inservice includes, but no limited to, the importance of care plant reviews and updates with a 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 the interventions are appropria and reflect the individual needs of each resident in	ny at te	
	I hit my head, staff ass (vital signs) as follows; 138/84, R (respirations (temperature) 98.0, O2			their care plan. The Directo of Nursing/designee will als audit the care plans of any new admissions weekly for six weeks to ensure that	- B	
	injuries, MAEW (mover (within normal limits), f WNL, resident c/o (con (headache) and back a (nurse practitioner) to r issues with fall, receive	s all extremities well) WNL ROM (range of motion) nplained of) bad h/a irea hurting, called NP		interventions are appropria and reflect the individual needs of each resident. Any issues identified will be		in the second

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER EEN HEALTH AND REHA	В		3	BTREET ADDRESS, CITY, STATE, ZIP CODE 180 MILLWOOD AVENUE WINCHESTER, VA 22601		
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	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 wnf (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."		F 657		addressed immediately by the Director of Nursing/designee and appropriate actions will be taken to update the reside 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 at least a quarterly basis.	ent on	
	risk for falls related to vigalt." There was no evigalt." There was no evigalt. There was no evigalt. There was no evigalt. There was no evigalt. The associated a request for the above documented On 4/13/22 at approxim (Administrative Staff Minursing provided a prindocumented nurse's no record and stated that the investigation. The above	veakness and unsteady vidence this care plan was after the above fall.  , a list of requested ed to the facility. This list the fall incident report of fall.  mately 4:30 PM, ASM #2 ember) the Director of tout of the above present above					

A95142  NAME OF PROVIDER OR SUPPLIER  EVERGREEN HEALTH AND REHAB  STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE	ED
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WINCHESTER, VA 22601	022
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	(X5) MPLETION DATE
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) process15. 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	

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F 657	treat or prevent certain	n infections.	F	657			
	comprehensive care p for Resident #16. On the most recent MI	ed review and revise the lan for the use of side rails  OS (Minimum Data Set), a with an ARD (Assessment					
		20/22, Resident #16 scored MS (brief interview for ng the resident was paired for making daily nt was coded as being					
	On 4/12/22 at 1:01 PM observed in bed with bi						
		record revealed a side rail 21 revealed the following responses:				1	
	use the side rails for be independently or with a Question #3, "The resid safety hazards when us Question #9, "The use o	lested use of the side lent is physically able to d positioning or transfer ssistance." lent is able to recognize					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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care provided and security." Question #17, use of side rail injury or entrape the above question #20.  A review of the revealed one do an ADL self-carto) gait and modementia" and 9/30/19 for "The weakness, resibalance during contained any in rails. Review of comprehensive evidence that the incorporated in On 4/13/22 at 4 conducted with Nurse). When a side rails, they splanned.  The facility policy condevelop and imperson-centered includes measure to meet a reside	"The use by staff "Resides and ir ment." of "Yes' stions. compressed at the performance of the resided dent de transition and other care places and other care places and other care places and other care places and other care places and other care preserved and the care prese	se of the side rail during will optimize resident safety ent's care plan addresses aterventions to minimize was marked for each of was marked for each of whensive care plan /1/16 for "The resident has rmance deficit r/t (related each of weakness and led 7/18/17 and revised on ent is risk for falls r/t monstrates impaired lons." Neither care plan tions for the use of side mainder of the an failed to reveal any of side rails was ler section, either.  an interview was (Licensed Practical is a resident who is using the planned for the use of that it should be care	F	657			

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		the review and updatin requested by the residerepresentative; b. Whe significant change in the When the desired outcomes on the resident has been in from a hospital stay; ar after each OBRA MDS  On 4/13/22 at 5:00 PM with ASM #1 (Administrator, and ASM Nursing were made aw further information was survey.  3. The facility staff failed comprehensive care place or a survey of the time of the survey of the most recent MDS quarterly assessment, were reported to the survey of the most recent MDS quarterly assessment, we was still on the present of the survey of the most recent MDS quarterly assessment, we was still on the present of the survey of the most recent MDS quarterly assessment, we was still on the present of the survey of the most recent MDS quarterly assessment, we was still on the present of the survey of the most recent MDS quarterly assessment, we was still on the present of the survey of the most recent MDS quarterly assessment, we was still on the present of the survey of the most recent MDS quarterly assessment, we was still on the present of the survey of the most recent MDS quarterly assessment, we was still the present of the survey of the most recent MDS quarterly assessment, we was still the present of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the most recent of the survey of the survey of the most recent of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the survey of the surve	asident Assessment ass15. The Care ary Team is responsible for ag of care plans: a. When ent / resident in there has been a ite resident's condition; c. ome is not met; d. When erences change; e. When readmitted to the facility and f. At least quarterly and assessment.".  at the end-of-day meeting rative Staff Member) the if #2 the Director of are of the findings. No provided by the end of the  d to review and revise the an for Resident #54 after a an 1/11/22. The wound sent active care plan at an 4/13/22.  S (Minimum Data Set), a with an ARD (Assessment 22, Resident #54 scored S (brief interview for ig the resident was aired for making daily was coded as being	F	557				
	A	review of the clinical re	ecord revealed a wound						

PRINTED: 04/22/2022 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495142 B. WING 04/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 75 F 657 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.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
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F 689 SS=D	goals, needs, and pre the resident has been from a hospital stay; a after each OBRA MDS On 4/13/22 at 5:00 PM with ASM #1 (Adminis Administrator, and AS Nursing were made as further information wa survey.	come is not met; d. When ferences change; e. When readmitted to the facility and f. At least quarterly and S assessment."  At the end-of-day meeting strative Staff Member) the M #2 the Director of ware of the findings. No s provided by the end of the ards/Supervision/Devices		689			
	as free of accident haz §483.25(d)(2)Each res supervision and assist accidents. This REQUIREMENT by: Based on observation interviews, clinical recodocument reviews it wis facility staff failed to en were free of safety haz Resident #36. Resider were observed to be vipotential safety hazard. The findings include:	re that - ident environment remains eards as is possible; and sident receives adequate ance devices to prevent is not met as evidenced , resident interviews, staff ord reviews and facility as determined that the isure 2 of 45 residents eards, Resident #56 and out #56 and #36's bed rails esibly loose creating a					
	<ol> <li>The facility staff falle #56's (R56) bed rail wa</li> </ol>	ed to ensure Resident is not loose, creating a					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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					rree of Accident		
F 689	Continued From page		F6	89	Hazards/Supervision/Device	5	
	potential safety hazard	d.			1.) Residents #36 and #56 have h	ıad	
	On the most recent M	DS (minimum data set), a			their bed rails assessed by sta	ff.	
		with an ARD (assessment		1	The resident's bed rails have		
		2022, the resident scored			been replaced and the new b	ed	
	15 out of 15 on the Bill mental status) assess	•			rails were tested to ensure		]
	resident is cognitively			ı	resident safety. Evergreen He	ath	
	decisions. Section G	documented R56 requiring			and Rehab has identified that		
	extensive assistance f					dil	
	members for bed mobi	ility.			residents are at risk from this		
	On 4/12/2022 at 4:10 t	o.m., an observation was		ı	alleged deficient practice.		
	-	oom. R56 was observed in			2.) The Administrator/designee I		
j		r bed rails on the bed. R56	1		performed an assessment of	all	
		he bed rails to shift their		- 1	resident's bed rails to ensure	that	
		organizer on the rail which ongings. R56 stated that			there are no loose rails which		
	the left bed rail was loc			- [	would create a safety hazard	for	
	shake the rail with their	r hand. R56 stated that			residents. Any variances have		
		omeone to come in to			been corrected by replacing t		
	• .	6 stated that the staff were loose and that it had been			loose bed rails. Any new rails		
	loose for "a couple of v				applied were tested to ensure	,	
						·	
	The most recent mainte	enance bed inspection for		- 1.	resident safety.		
T I		ed and was completed on		-	3.) The Administrator/designee h	as	
	2/21/2022.				in-serviced staff on the		
	Review of R56's clinica	l record documented a		- }	Maintenance Director and Nu	rses	
- 1		10/28/2020 and a side rail			of providing an environment	:hat	
1	entrapment risk assess				is free of resident safety		
					concerns. The in-service inclu	ded,	
	The comprehensive car documented in part, "R				but was not limited to,	·	
		esident requires activities of daily living) r/t			performing bed rail assessme	nts	
	(related to) impaired mo				upon admission and bed chan		
	03/15/2019"	· · · · · · · · · · · · · · · · · · ·			•	ges,	
					and performing routine	. ]	

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	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRI DEFICIENCY)	
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 rall 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 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 cail or put into the computer. LPN #4	facility to ensure the present a potential of to residents. Strator/designee with unit in the facility weeks to ensure	li co II en Is.
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		

#### **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		UCTION	(X3) DATE SURVEY COMPLETED	
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F 689	documented in part, ". measures to develop a minimize the possibilit and or injury while using On 4/13/2022 at appropriate app	d Rail Risk and Safety"This organization will take and implement a strategy to y of resident entrapment ng bed rails"  eximately 5:00 p.m., ASM ASM #2, the director of the regional nurse	F	689			
	quarterly assessment of reference date) of 2/1/2 14 out of 15 on the BIM mental status) assessment is cognitively in decisions. Section G dextensive assistance from members for bed mobil On 4/12/2022 at 3:54 pmade of R36 in their robed with bilateral upper stated that did not use to because they were loos rail was the worst one a	as not loose, creating a  DS (minimum data set), a with an ARD (assessment 2022, the resident scored as (brief interview for ment, indicating the ntact for making daily locumented R36 requiring om two or more staff lity.  I.m., an observation was om. R36 was observed in the bed R36 reduction was ome rate on the bed R36 reduction was ome rate on the bed R36 reduction was one rate on the bed R36					

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	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	3		3	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	was visibly loose from one of the nurses had calling maintenance to and their roommates but no one had ever control of the most recent maintenance to and their roommates but no one had ever control of the most recent maintenance of the most recent maintenance or the most recent maintenance of the maintenance of the maintenance of the maintenance of the maintenance of the most of the most of the maintenance of the most of th	the bed and stated that told them that they were come in to fix their bed rail ped rail about a month ago ome in.  Tenance bed inspection for ed and was completed on all record documented a intrapment assessment  The plan for R36 desident requires extensive factivities of daily living) r/t mobility. Date Initiated:  The director was on leave terview.  The plan for R36 desident requires extensive factivities of daily living) r/t mobility. Date Initiated:  The director was on leave terview.  The plan for R36 desident requires extensive factivities of daily living) r/t mobility. Date Initiated:  The director was on leave terview.  The plan for R36 desident requires extensive factivities of daily living) r/t mobility. Date Initiated:  The director was on leave terview.  The plan for R36 desident requires extensive factivities of daily living) r/t mobility. Date Initiated:  The director was on leave terview.  The plan for R36 desident requires extensive factivities of daily living) r/t mobility. Date Initiated:	F	589			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	27	495142	B, WING_		04	C 1/14/2022
	PROVIDER OR SUPPLIER EEN HEALTH AND REHA	В		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 689	left bed rail in R36's ro left rail on R36's bed v and stated that it need ASM #1 attempted to the bed and stated tha	administrator observed the norm. ASM #1 observed the when the resident shook it	F6	89		
	On 4/13/2022 at 12:40 conducted with LPN (II LPN #4 stated that a b consent was complete bed rails. LPN #4 statissues were reported ophone call or put into the stated that they were muith loose bed rails but immediately because the LPN #4 stated that the	p.m., an interview was censed practical nurse) #4. ed rail assessment and d for residents who used ed that any maintenance lirectly to maintenance by a he computer. LPN #4 not aware of any residents they would report them hey were a safety hazard. resident could get their they could fall out of bed				
ŀ	On 4/13/2022 at approx #1, the administrator, A nursing, and ASM #4, t consultant were made a concern.	he regional nurse				
F 695		was provided prior to exit. omy Care and Suctioning	F 69	5	į	
	§ 483.25(i) Respiratory tracheostomy care and The facility must ensure needs respiratory care, care and tracheal suction	tracheal suctioning.  that a resident who including tracheostomy				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		40.74.40			С	
		495142	B. WING		04/14/2022	
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	3		STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA 22601	Ш	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	care, consistent with practice, the comprehence plan, the resident and 483.65 of this sub This REQUIREMENT by: Based on observation interviews, clinical recodocument review it was facility staff failed to accordered to two of 45 resample, Resident #93 The findings include:  1. The facility staff faile ordered and in a sanital (R93).  On the most recent ME admission assessment reference date) of 3/13 11 out of 15 on the BIM mental status) assessment	professional standards of ensive person-centered is goals and preferences, part.  is not met as evidenced in resident interviews, staff ord reviews and facility is determined that the similater oxygen as esidents in the survey and #117.  Bed to administer oxygen as any manner to Resident #93  OS (minimum data set), and with an ARD (assessment /2022, the resident scored	F 69	F695/12 VAC 5-371-220 (A)-Respiratory/Tracheostomy Ca and Suctioning  1.) Oxygen orders for resident #93 have been reviewed and clarificand the resident is receiving the correct amount of oxygen per provider orders and the oxyge tubing is correctly dated and stored in a sanitary manner. The residents' plans of care were reviewed and updated to include	de de the n	
	R93 was coded as usir at the facility.	g oxygen while a resident		resident-specific needs. Residen #117 is not currently a residen Evergreen Health and Rehab,	I I	
	was observed lying in to R93's bed. The oxyger observed to be on with (liters per minute). Who oxygen, R93 stated tha	on oxygen nasal cannula the floor to the left side of the concentrator was the oxygen set at 2 lpm the asked about the t they wore the oxygen that the nurses put the the asked if R93 ever		therefore no interventions we appropriate at this time. Evergreen Health and Rehab hidentified that all residents are risk from this alleged deficient practice.	as e at	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495142	B. WING				14/2022
NAME OF F	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		THEOLE
EVERGR	EEN HEALTH AND REHAI	3	-	3	380 MILLWOOD AVENUE		
			<b> </b>	٧	WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	83	F	895	An observation audit of reside oxygen administration amount		
	Additional observation	s on 4/12/2022 at 2:45			was performed on residents		
	p.m., 4:18 p.m. and 4/				receiving oxygen and the		İ
		servation as stated above.	}				
	The position of the nas	sal cannula remained in the			amounts were compared to the	ne	]
	floor to the left side of				provider's orders. The		i
		oxygen set at 2 lpm. Staff			observation included ensuring		ļ <b>[</b>
		g and exiting R93's room	ļ	i	that oxygen tubing was prope	rlv	ł
		vices, upon exit the nasal he floor to the left side of			dated and stored in a sanitary		- 1
		ne licor to the left side of intrator running at 2 lpm.			·	I	- 1
	the bed with the corlec	illustor running at 2 ipm.			manner. Any discrepancies we	re	ŀ
	The physician orders d	locumented in part.	ļ		immediately corrected, and		
		minute, verify O2 (oxygen)	[		orders were verified or clarifie	d	i
	setting at eye level. O				with the provider.	- [	
					3.) The Director of Nursing/design		1
1	The comprehensive ca						- 1
		he resident has aftered			has in-serviced licensed nurses		
i	respiratory status/diffic				(RNs and LPNs) regarding oxyg	en	ĺ
	evidenced by) O2 via N continuous. Date Initia				administration and sanitary		}
	COMMINUOUS. Date Milita	18d. 03/0//2022.			storage. The in-service include	ς .	i
	On 4/13/2022 at 12:40	n.m. an interview was				"	Į.
		censed practical nurse) #4.		l	but is not limited to, the		
	LPN #4 stated that oxy			ļ	importance of administering		
	whenever they went int				oxygen per provider's orders	and	
	stated that if a resident	was not using their			clarifying oxygen orders if the	re is	j
		n a plastic bag to keep it			any variance between what is		İ
		d R93's room, observed			ordered and what is stated	,	[
		was previously observed					
		f the bed on the bed under was made aware of the			elsewhere in the medical reco	ord,	
		was made aware or the 022 and 4/13/2022 at 8:05			as well as sanitary storage of	1	
<b>I</b>	a.m., and stated that at				oxygen tubing.		ļ
		threw it on the floor. LPN					
		uld be documenting those		-			
		il record and notifying the					
		ed that R93 tells them he					
		en when he takes it off.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING				(X3) DATE SURVEY COMPLETED			
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		495142	B. WING			04	/14/2022
	PROVIDER OR SUPPLIER EEN HEALTH AND REHAL	В		3	STREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	LPN #4 stated that the the oxygen each time provide care and storic bag if R93 was refusing. The facility policy "Oxydocumented in part, ". procedure, the reason taken"  On 4/13/2022 at approximation (administrative staff meadministrator, ASM #2 and ASM #4, the regio made aware of the find	e staff should be checking they enter the room to ng the cannula in a plastic g to wear it.  /gen Administration* If the resident refused the (s) why and the intervention  eximately 5:00 p.m., ASM ember) #1, the , the director of nursing, nal nurse consultant were	F	595	will perform an audit to compall oxygen orders to amounts administered weekly for six weeks to ensure that oxygen being administered as per provider orders. The Director Nursing/designee will perfor observation audits of all residence iving oxygen weekly for sweeks to ensure that tubing it dated and stored in a sanitary manner. Any issues identified be addressed immediately by Director of Nursing/designee appropriate actions will be ta	oare  of n lents ix s / will and ken.	
	therapy as ordered for #117 was observed wit oxygen set at four liters at 1:30 PM, 4/12/22 at 8:25 AM  Resident #117 was adm 3/22/22 with diagnoses limited to: Congestive I fibrillation and atherosodisease.  Resident #117's most reset) assessment, a Medwith an assessment referenced.	nasal cannula on 4/12/22 4:15 PM and on 4/13/22 at  nitted to the facility on that include but are not heart fallure, atrial			The Director of Nursing/design will identify any trends and/of patterns and additional education and training will be provided to staff on an ongoin basis. Findings will be discuss with the QAPI committee on least a quarterly basis.  5.) Date of Compliance: 5/16/20	r ed at	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		495142	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	700172	15	,	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	/14/2022
10000					380 MILLWOOD AVENUE		
EVERGRE	EN HEALTH AND REHA	3		Ι.	WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES If MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix I	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	indicating the resident Impaired. The resident extensive assistance I dressing, toileting, bat supervision with eating. Resident #117's care at the following, "Focus: hospice for end of life oxygen for shortness of the physicing revealed the following, minute via nasal cannot at eye level."  A review of Resident # (treatment administrating "Oxygen at 2 liters per Diagnosis of: verify O2 shift" with documentating with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift" with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating the per Diagnosis of: verify O2 shift with documentating	was moderately cognitively twas coded as requiring n bed mobility, transfers, hing and personal hygiene; g.  clan dated 4/1/22, revealed Resident is receiving care. Interventions: Utilize of breath and comfort."  an's orders dated 3/22/22, "Oxygen at 2 liters per ula. Verify oxygen setting  117's April 2022 TAR on record), which reveals, minute via NC Due to setting at eye level every on for all three shifts. From the with Resident #117  When asked about her not #117 think it is sure.  Lucted on 4/13/22 at 8:25  practical nurse) #4. When for Resident #117's was wn to review oxygen oxygen is set at 4 liters d be at 2 liters nasal ted the oxygen setting to 2 then asked how you	F	695			
18	snould read the oxygen	setting, LPN #4 stated,					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B. WING			C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA 22601		4/14/2022	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHOTE CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 700 SS=D	the ball should be in the should be viewing at a condition of the above administrator, ASM #2, ASM #4, the regional informed of the above according to the facility policy with no date, who "Review the physician for oxygen administrated according to the oxygen annual, which reveals supplemental oxygen, flow meter switch left of the flow meter centers and the prescribed oxygen and	ne middle of the line and we eye level.  A, ASM #1, the c, the director of nursing and nurse consultant, were concern.  Y's "Oxygen Administration" nich revealed the following, c orders or facility protocol ion."  en concentrator's user, "To set the flow of turn the knob of oxygen or right until the ball inside on the flow line number or gen flow."  was provided prior to exit.	F 6	595			
	bed rails with the reside	he resident for risk of ails prior to installation.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED			
	j		925				С	
		495142	B. WING				/14/2022	
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В	STREET ADDRESS, CITY, STATE, ZIP CODE  380 MILLWOOD AVENUE  WINCHESTER, VA 22601					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(XS) COMPLETION DATE	
F 700	Continued From page to installation.	87	F 70	00	F700- Bedrails			
				1	) Bed rail assessments were			
		that the bed's dimensions			completed for residents #93	and		
	are appropriate for the	resident's size and weight.			#54. The residents' care pla			
	   §483.25(n)(4)	he manufacturers'			have been updated to refle			
		specifications for installing			current individualized plan			
	and maintaining bed ra	ails.		}	care. Evergreen Heath and I			
		is not met as evidenced			has identified that all reside			
	by: Based on observation	n, resident interviews, staff			are at risk from this alleged	111.5		
		ord reviews and facility			<del>-</del>			
	document review it wa	s determined that the			deficient practice.	·		
		ssess 2 of 45 residents in		2	.) The Director of Nursing/des	-		
	the survey sample for the Resident #93 and #54.				has performed an assessme			
	Resident #35 and #54.	1			audit of all current resident			
	The findings include:				ensure that bed rail assessn	nents		
	-				have been completed. Any			
	1. The facility staff faile				variances have been addres	sed		
		e of bed rails for Resident			and care plans have been			
	#93 (R93).				updated to reflect a current			
	On the most recent ME	OS (minimum data set), an			individualized plan of care.			
	admission assessment	with an ARD (assessment		,	3.) The Director of Nursing/des	ionee		
		/2022, the resident scored		ر ا	has in-serviced licensed nur			
	11 out of 15 on the BIM							
		nent indicating the resident for making daily decisions.			staff, including LPNs and RN			
		uiring extensive assistance			regarding completion of be			
		mbers for bed mobility.			assessments. The in-service			
					includes, but no limited to,			
L L	An observation on 4/12	• •			importance of completing t	he		
		th bilateral mid bed rails up ed about the bed rails, R93			bedrail assessment in a tim	ely		
	stated that they use the				and accurate manner to en	sure		
	·				resident safety.			
/ <i>/</i>	Additional observations					1		
	n m 4·18 n m and 4/1:	3/2022 at 8:05 a m	1	1			1	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT		(X3) DATE SURVEY COMPLETED		
		495142	B. WING			I	С
NAME	OF PROVIDER OR SUPPLIER	700172	10	ST	REET ADDRESS, CITY, STATE, ZIP CODE	04	/14/2022
EVE	GREEN HEALTH AND REHA	В	:	38	0 MILLWOOD AVENUE INCHESTER, VA 22601		
(X4) PRE TA	X (EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE
F	Review of R93's clinic documentation of an a bed rails.  The comprehensive can documented in part, "(activities of dally living deficit AEB (as eviden generalized weakness Date Initiated: 03/07/2 rails up for safety during with bed mobility. Obsentrapment related to necessary to avoid injuition of a written list to ASM member) #1, the adminassessment, bed inspection completed in the director of nursinspection completed in bed on 2/21/2022, and with a bed rail consent assessment.  On 4/13/2022 at 12:40 conducted with LPN (lict LPN #4 stated that a becompleted in the completed in the completed in the completed in the completed assessment.	al record failed to evidence assessment for the use of are plan for R93 The resident has an ADL and self-care performance and self-care performance and self-care performance and self-care performance and self-care performance and self-care performance and self-care provision, to assist an are provision, to assist an are provision, to assist an are provision as an are provision as an are provision as an are provision as an are provision as an are provision as an are provised as an admission agreement and an are provided a bed by maintenance for R93's an admission agreement and an are provided and are provided and	F7	700	the Director of Nursing/design and appropriate corrective actions will be taken. The Director of Nursing/designee videntify 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 quarte basis.  5.) Date of Compliance: 5/16/202	will	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
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		495142	B. WING			04	/14/2022
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		36	TREET ADDRESS, CITY, STATE, 2IP CODE 80 MILLWOOD AVENUE /INCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 700	page	p.m., ASM #2 stated that	F	700			
	assessment completed they did not have one	d in the medical record and to provide.					
	determine whether the and bed mobility is impled rail(s), to identify a constitute physical rest individual characteristic risk of entrapment by bed rail evaluation, incicomponent, is complete Readmission"	Any resident being bed with bed rail(s) is y's interdisciplinary team to resident's functional status proved through the use of any bed rail that might train, and to identify cs that may increase the ped rails or mattress. The luding the entrapment risk ed: a. Admission,  eximately 5:00 p.m., ASM ASM #2, the director of he regional nurse					
}		was provided prior to exit.					
1	evaluation prior to imple rails for Resident #54.	ed to complete a side rail ementing the use of side					
C   F   E	quarterly assessment, v						

C	-
495142   B. WING   0444400	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	/14/2022
EVERGREEN HEALTH AND REHAB  380 MILLWOOD AVENUE WINCHESTER, VA 22601	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETION DATE
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 up.  A review of the comprehensive care plan revealed one dated 10/7/21 for "The resident has an ADL self-care performance deficit rit (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 falled 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 seasessment 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	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRU	CTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING			1	C /14/2022
	ROVIDER OR SUPPLIER EEN HEALTH AND REHA	В		380 MILLWO	ORESS, CITY, STATE, ZIP CODE DOD AVENUE FER, VA 22601		1111000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 730 SS=E	rails. This will include who have a need for cand that may have cheat special risk for entra Resident: 1. Any residusing a bed with bed reacility's interdisciplina whether the resident's mobility is improved the rail(s), to identify any to physical restraint, and characteristics that may entrapment by bed rail.  On 4/13/22 at 5:00 PM with ASM #1 (Administ Administrator, and ASM Nursing were made aw further information was survey.  Nurse Aide Peform Rec CFR(s): 483.35(d)(7)  §483.35(d)(7) Regular The facility must complete on the reviews. In-service trairequirements of §483.9 This REQUIREMENT in the sail of the review, it was determinated to complete an arregular trairequirements of sail of the review, it was determinated to complete an arregular traired to complete an arregular traired to complete an arregular traired to complete an arregular traired to complete an arregular traired to complete an arregular traired to complete an arregular traired to complete an arregular traired to complete an arregular traired tr	an evaluation of residents or desire to use bed ralls aracteristics that place them apmentAssess the ent being considered for ail(s) is evaluated by the ry team to determine functional status and bed rough the use of bed bed rail that might constitute to identify individual by increase the risk of s or mattress."  If at the end-of-day meeting rative Staff Member) the WH2 the Director of vare of the findings. No sprovided by the end of the view-12 hr/yr In-Service  in-service education.  ete a performance review east once every 12 ide regular in-service outcome of these ning must comply with the 15(g). Is not met as evidenced we and facility document end that the facility staff	F7	30			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
			A BOILD				С
		495142	B. WING				/14/2022
	PROVIDER OR SUPPLIER	В		3	STREET ADDRESS, CITY, STATE, ZIP CODE 180 MILLWOOD AVENUE VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD 8 CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 730	The facility staff failed	to complete an annual or CNA #2, CNA #3, CNA	F	730	F730- Nurse Aide Performan Review  1. The facility has completed ar		
	CNA #2 was hired on 3 #2's record failed to re reviews.		ω.		performance reviews for CNA #2, #3, #4, #5 and #6. In-ser education was provided to t CNAs based on the outcome	vice the e of	
	CNA #3 was hired on 3/18/19. A #3's record failed to reveal any pereviews.	veal any performance		9)	the reviews. Evergreen Heal and Rehab has determined the all residents have the poten	that	
	#4's record revealed th was completed on 10/1				be affected by this alleged deficient practice.  2. The Director of Nursing/design and the deficient practice.	_	
		1/27/09. A review of CNA e last performance review 1/18.			has completed an audit of 1 month performance reviews all CNAs currently employed	for by	
İ		/1/99. A review of CNA e last performance review 18.			the facility. Any variances fo have been corrected and all currently employed CNAs ha	ıve	
	director keeps a record annual performance rev her a list of performance	dministrative staff or of nursing). ASM #2 iews should be done ed the human resources of when employees' riews are due and gives e reviews that need to be nat usually she completes s them to the assistant nurse on the unit. ASM review is done and			had a 12-month performanc review completed.	e 22%	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL			RUCTION	(X3) DATE COME	SURVEY PLETED
		495142	8. WING				ļ.	С
NAME OF S	PROVIDER OR SUPPLIER	433142	J 0. WINO .	07/		ADDRESS, CITY, STATE, ZIP CODE	04	14/2022
	EEN HEALTH AND REHA	В		380 MILLWOOD AVENUE WINCHESTER, VA 22601				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	. 3.	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) The Director of Nursing/desi	TE	(X5) COMPLETION DATE
F 730	be filed.  The human resources employed at the facilit.  On 4/13/22 at 5:02 p.n administrator) and ASI the above concern.  The facility policy titled	human resources director to director was no longer y. n., ASM #1 (the M #2 were made aware of d, "Performance tted, "The job performance tted, "The job performance	F	730		has in-serviced nursing management and Human Resources staff on the importance of conducting ar CNA performance reviews all providing in-service education based on the outcome of the reviews. The education included but was not limited to, proceed for conducting the annual performance review, performance benchmarks, as	nnual nd on e ded, edure	
	No further information Posted Nurse Staffing CFR(s): 483.35(g)(1)-( §483.35(g) Nurse Staff §483.35(g)(1) Data req must post the following basis: (i) Facility name. (ii) The current date. (iii) The total number at by the following catego unlicensed nursing staff resident care per shift: (A) Registered nurses. (B) Licensed practical r vocational nurses (as d (C) Certified nurse aide	was presented prior to exit. Information 4) fing Information. guirements. The facility information on a daily and the actual hours worked ries of licensed and if directly responsible for hurses or licensed lefined under State law).	F7	32	4.	identifying areas of CNA performance requiring in-ser education. The Director of Nursing/Desi will perform an audit of annu CNA performance reviews monthly for three months to ensure that the reviews are completed, and in-service education is provided based the outcome of the reviews. Director of Nursing/designee identify any trends and/or patterns and additional education and training will be	gnee Jal On The will	
		equirements. t the nurse staffing data (g)(1) of this section on a			5.	provided on an ongoing bas Findings will be discussed w the QAPI committee on at le quarterly basis. Date of Compliance: 5/16/20	ith east a	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	S IMPLIC				С
NAMEOER	ROVIDER OR SUPPLIER	485142	B. WING			04	/14/2022
NAME OF F	ROVIDER OR SUFFLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGR	EEN HEALTH AND REHAL	В			80 MILLWOOD AVENUE		
	SUMMADV STA	TEMENT OF DEFICIENCIES			VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 732	Continued From page	94	F	732	F732- Posted Nurse Staffing		
i	daily basis at the begin	nning of each shift.		-	Information		
	(ii) Data must be poste	ed as follows:					
	(A) Clear and readable				1.) Facility staff have corrected		
	residents and visitors.	ce readily accessible to			alleged deficient practice. The		
	residents and visitors.				daily nursing staff report is b	eing	
	§483.35(g)(3) Public a	ccess to posted nurse			posted at the nurses' station		
	staffing data. The faci				daily with documentation of	the	
	written request, make				facility name and separated		
	exceed the community	for review at a cost not to	İ		actual hours and total number	er of	}
	oncode and dominionary	dandard,		- 1	RNs (registered nurses) and I	PNs	
	§483.35(g)(4) Facility (				(licensed practical nurses).		
İ	requirements. The fac				2.) Director of Nursing/designee	has	
}		fing data for a minimum of red by State law, whichever	!	ŀ	reviewed daily nursing staff		İ
	is greater.	od by otate law, willoffever	1		report and ensured that it wa	30	
		is not met as evidenced			posted visible to the public d		
	by:	ah-85 (-h 2			Audits of posting have been	ally.	
i	document review, it wa	staff interview and facility		- 1	performed since 5/1/22 and	4	
		st complete nurse staffing	!		results are being tracked ar	nd	
	information.	-			variances addressed		
	Nurse staffing informati	ion posted on 4/13/22		ı	appropriately by Director of	F	
		facility name and failed to			Nursing/designee.	' i	
	separate the actual hou			1	3.) The Director of Nursing/des	ian	
	RNs (registered nurses	) and LPNs (licensed			has in-serviced the staffing	ignee	1
	practical nurses).	,			coordinator and nurse mana		
	The findings include:				On posting accurate start	igers	ŀ
-	-				on posting accurate daily sta	itting	
	On 4/13/22 at 10:15 a.n				numbers. The in-service incl	udes	1
	information posting was				but is not limited to, how to	85	
]	nail. The posting tailed	to document the facility arate the actual hours and		-	accurately complete the dail	у	
- 1	otal number of RNs and	d LPNs. The actual hours			nursing staff report and whe	re to	
	and total number of RN				post this information so that	it is	
	combined.				visible to general public.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		[ , ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B, WING		<del></del>	1	C
NAME OF P	ROVIDER OR SUPPLIER	100072	1		STREET ADDRESS, CITY, STATE, ZIP CODE	04/	/14/2022
EVERGRI	EEN HEALTH AND REHA	8		3	380 MILLWOOD AVENUE WINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI- DEFICIENCY)		(X5) COMPLETION DATE
	On 4/13/22 at 1:25 p.i conducted with OSM person responsible fo stated she should data resident census on the total number of RNs, I nursing assistants) an assistants) then docur hours for each position posting should separatotal number and actustated the posting should name and she did not documented.  On 4/13/22 at 5:02 p.m staff member) #1 (the (the director of nursing above concern.  The facility policy titled Staffing" documented, Information shall be redesignated form for earecorded on the form sa. The name of the fac b. The date for which the c. The resident census shift for which the inford. Twenty-four (24)-hou by the facility.  e. The shift for which the f. Type (RN, LPN, LVN, LVN, LVN, LVN, LVN, LVN, LVN, LV	m., an interview was (other staff member) #6 (the r the posting). OSM #6 e the posting, document the posting, document the PNS, TNAS (temporary d CNAS (certified nursing ment the total number of n. OSM #6 stated the te RNs and LPNs for the al hours. OSM #6 further uld document the facility realize this was not  n., ASM (administrative administrator) and ASM #2 ) were made aware of the  , "Posting Direct Care Daily "3. Shift staffing corded on the facility ch shift. The information hall include the following: ility. ne information is posted. at the beginning of the mation is posted. or shift schedule operated the information is posted. ar shift schedule operated the information is posted. or CNA) and category ed) of nursing staff working the during that shift for of nursing staff.	F	732	4.) The Director of Nursing/de will review daily postings for placement and accuracy we for six weeks. Any issues identified will be addressed immediately by the Director Nursing/designee and appropriate action will be to The Director of Nursing/designee will identify any trends and patterns, and additional education and training will provided to employees on a ongoing basis. Findings will discussed with the QAPI committee on at least a quabasis.  5.) Date of Compliance: 5/16/2	or eekly I or of aken. signee /or be an be	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING		· · · · · · · · · · · · · · · · · · ·	C 04/14/2022	
}	PROVIDER OR SUPPLIER EEN HEALTH AND REHAL	В		38	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE VINCHESTER, VA 22601	ONTHEGE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		
	nursing staff working fi. Any additional inforn regulation/guidance."  No further information Food Procurement, Stc CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety The facility must - §483.60(i) Food safety The facility must - §483.60(i)(1) - Procure approved or considere state or local authoritie (i) This may include for from local producers, s and local laws or reguli (ii) This provision does facilities from using progardens, subject to corsafe growing and food-(iii) This provision does from consuming foods §483.60(i)(2) - Store, p serve food in accordance standards for food serve This REQUIREMENT is by:  Based on observation, document review, it was facility staff failed to stomanner in 1 of 1 facility  The findings include:  On 4/12/22 at approxim	or the posted shift, nation required by state  was presented prior to exit, pre/Prepare/Serve-Sanitary  requirements.  food from sources disatisfactory by federal, so ditems obtained directly subject to applicable State ations.  not prohibit or prevent duce grown in facility inpliance with applicable handling practices.  not preclude residents into procured by the facility.  repare, distribute and ce with professional lice safety.  s not met as evidenced  staff interview and facility is determined that the refood in a sanitary kitchens.		732	F812- Food Procurement, Store/Prepare/Serve-Sanis  1. Certified Dietary Manager/Conhas performed a walk-through inspection and discarded out date items and has ensured a products were sealed and lab correctly. It is the policy of Evergreen Health and Rehabensure food is procured, store and prepared in a sanitary manner. Residents receiving meals from the kitchen have potential to be affected by the alleged deficient practice.  2. The Certified Dietary Manager/designee has performed morning and even walk-through inspections to verify all items are sealed, labeled, and dated per policy. Any items found out of compliance have been discard.  3. The Certified Dietary Manager/designee has reeducated culinary staff on the proper labeling/dating/sealing stored food as per policy. The education included, but was	ook th -of- all beled to red, the nis  rided.	

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI			STRUCTION	(X3) DATE SURVEY COMPLETED	
	;	495142	B. WING	NG				С
NAME OF I	PROVIDER OR SUPPLIER	453142	D. WING	S	TREET	TADDRESS, CITY, STATE, ZIP CODE	04	1/14/2022
EVERGR	EEN HEALTH AND REHAI	3	380 MILLWOOD AVENUE WINCHESTER, VA 22601					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X6) COMPLETION DATE
	Staff Member) the Die The reach-in fridge wa pan of bacon and saus a pan of ground beef, a pan of creamed corn and dated. This reach pan of pancakes and te scrambled eggs, neithe covered. Both pans ha which was pulled back food items to the environ fridge.  A walk-in fridge contain were bagged. A bag we sticking out, exposing te environment in the wall  On 4/12/22 at approxim stated that these items labeled and dated.  The facility policy "Rece Food" was reviewed. T "All foods stored in the be covered, labeled and On 4/13/22 at 5:00 PM with ASM #1 (Administr Administrator, and ASM Nursing were made awa	tary Manager.  Its identified to contain a sage, a pan of beef patties, a pan of tomato soup, and a land which were not labeled in fridge also contained a past and a pan of the which were properly and plastic wrap over them, on one side, exposing the comment of the reach-in the lettuce to the k-in fridge.  Inately 12:30, OSM #7 should be covered,  Selving and Storage of this policy documented, refrigerator or freezer will at dated ("use by" date)."  at the end-of-day meeting ative Staff Member) the l#2 the Director of	F	312	<b>4</b> .	limited to, sanitary food storal labeling, dating, and wasting out-of-date food. Certified Dietary Manager/designee will perfor AM/PM walk-through audits 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 an trends/patterns to the QAPI committee on a quarterly bas Date of Compliance: 5/16/20	of rm daily ure s.	
F 842 SS=D	survey. Resident Records - Ider CFR(s): 483.20(f)(5), 48 §483.20(f)(5) Resident-i	3.70(i)(1)-(5)	F 84	12				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B. WING				С	
NAME OF P	ROVIDER OR SUPPLIER		1	ST	REET	ADDRESS, CITY, STATE, ZIP CODE	04/	14/2022
EVERGRE	EN HEALTH AND REHAL					LWOOD AVENUE		
EVERGILE	EN HEACHT AND RCHA		1	W	INCH	IESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
						F842/12VAC5-371-360(E)(9)	- 1	
F 842	Continued From page	98	F8	342		Resident Records - Identifial	ole	ĺ
	(i) A facility may not release information that is resident-identifiable to the public.		:			Information	i	
	resident-identifiable to				1.			
- 1	accordance with a con	tract under which the agent	1			interviewed by nursing staff	and	
	agrees not to use or di		1			the resident's provider and		- 1
	to do so.	e facility itself is permitted				representative were made av	vare	j
	10 do 30,					of the missing documentation	n of 🐰	
ļ	§483.70(i) Medical rec	ords.				insulin administration. The	(1)	
	§483.70(i)(1) In accord					resident's plan of care was		i
i		and practices, the facility				reviewed and updated to refl		
	must maintain medical that are-	records on each resident					eci	
	(i) Complete;					their resident-specific needs		
	(ii) Accurately documer	nted:				regarding resident's right and		14
	(iii) Readily accessible;					preference pertaining to refu		
1	(iv) Systematically orga	nized				of medications. Evergreen He	ath	
			l			and Rehab has identified that	all	ĺ
		y must keep confidential				residents are at risk from this		- 1
		d in the resident's records, or storage method of the				alleged deficient practice.		
	records, except when re				2	The Director of Nursing/desig	nao	
	(i) To the individual, or t				٠.	has audited the Medication	nee	i
	representative where po	ermitted by applicable law;						}
	(ii) Required by Law;					Administration Record of		
	(iii) For treatment, paym					residents with insulin orders		1
	operations, as permitted with 45 CFR 164.506;	o by and in compliance	ļ			current residents. Nursing has	;	
		tivities, reporting of abuse,		-		notified residents, responsible	<u> </u>	1
r	neglect, or domestic vio	lence, health oversight				parties and provider any		i
8	activities, judicial and ad	dministrative proceedings,				variances, and has ensured th	at	
1	aw enforcement purpos	ses, organ donation				care plan interventions are		
F	ourposes, research pur	poses, or to coroners,				appropriate and address resid		
		eral directors, and to avert h or safety as permitted					ent	
	y and in compliance wi					specific care needs regarding		
"	, verriphono W					resident's right and preference	e	
						pertaining to refusal of		
RM CMS-2587(0	2-99) Previous Versions Obsolet	e Event ID: JV0T11		Facility	- y ID;  \	medications. VA0218 If continuati	ــــــ on sheet Pa	age 99 of 109

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 04/22/2022 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495142 B. WING 04/14/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE **EVERGREEN HEALTH AND REHAB** WINCHESTER, VA 22601 SUMMARY STATEMENT OF DEFICIENCIES (X4) (D PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 1. The Director of Nursing/designee Continued From page 99 F 842 has educated clinical staff, §483.70(I)(3) The facility must safeguard medical record information against loss, destruction, or including RNs and LPNs regarding unauthorized use. complete and accurate documentation in medication §483.70(i)(4) Medical records must be retained administration records. The (i) The period of time required by State law; or education includes, but is not (ii) Five years from the date of discharge when limited to, the importance of there is no requirement in State law; or (ill) For a minor, 3 years after a resident reaches accurate and complete legal age under State law. documentation of medications administered, and how to §483.70(i)(5) The medical record must containdocument a resident refusal of a medication or if a medication is (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments: not administered. (iii) The comprehensive plan of care and services 4. The Director of Nursing/designee (iv) The results of any preadmission screening will audit 25% of the Medication and resident review evaluations and Administration Record (MAR) for determinations conducted by the State: (v) Physician's, nurse's, and other licensed residents with Insulin orders professional's progress notes; and weekly for six weeks to ensure (vi) Laboratory, radiology and other diagnostic that documentation is accurate services reports as required under §483.50. This REQUIREMENT is not met as evidenced and complete. Any issues by: identified will be addressed Based on clinical record reviews, facility immediately by Director of document review and staff interview it was determined that the facility failed to maintain a Nursing/designee and complete and accurate clinical record for one of appropriate actions will be taken. 45 residents in the survey sample, Resident #31 The Director of Nursing/designee (R31). will identify any trends and/or The findings include: patterns, and provide education as needed on an ongoing basis. The facility staff failed to maintain a complete and

administration for R31.

accurate clinical record documenting insulin

quarterly basis.

Findings will be discussed with

the QAPI committee on at least a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD			(X3) DATE SURVEY COMPLETED	
		495142	B. WING				C 4/14/2022
	PROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		38	REET ADDRESS, CITY, STATE, ZIP CODE 0 MILLWOOD AVENUE INCHESTER, VA 22601	1 0	4/ 14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
1 1 2 1 2 7	On the most recent MI quarterly assessment Reference Date) of 1/2 interview for mental state completed. On the president scored 15 out assessment, indicating cognitively Impaired for The physician orders for "11/27/2020 Insulin A: Pen-Injector 100 Unit/N subcutaneously before Diabetes Mellitus with I Unspecified."  The eMAR (electronic record) dated 3/1/2022 to evidence documenta FlexPen Solution Pen-Indates, on 3/5/3022 at 6: 30 a.m., and 3/27/20	DS (minimum data set), a with an ARD (Assessment 24/2022, the BIMS (brief atus) assessment was not evious quarterly RD of 12/30/2021 the of 15 on the BIMS at the resident is not r making daily decisions.  DO R31 documented in part, spart FlexPen Solution AL (milliliter), Inject meals related to Type 2 Diabetic Neuropathy  medication administration a/3/1/2022) for R31 failed tion for the Insulin Aspart injector on the following a.m., 3/6/2022 at 6:30 a.m., 3/23/2022 at 6:30 a.m., The areas for a medication for the Insulin a Pen-Injector on the 2022 at 6:30 a.m. The on of the medication on	F	842			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
1						С	
		495142	B. WING			0.	4/14/2022
NAME OF P	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
EVERGRE	EEN HEALTH AND REHAI	В		3	80 MILLWOOD AVENUE		
				٧	VINCHESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	101	F	B42			
	On 4/14/2022 at 7:44	a.m., an interview was					
		icensed practical nurse) #4.	1				i
		y were not sure what the	1				
	blank areas on the eM		ĺ				
	reviewed the eMAR fo						
		vith blanks on the dates					1
	refused the medication	stated that R31 may have					
		locumenting the refusal.					1
	Something in the box o	comenting the releast.		j			]
1	On 4/14/2022 at 7:50 a	a.m., an interview was		- 1			
	conducted with LPN #1	1. LPN #1 stated that					1
		ay mean that the resident		ĺ			1
		ng or may have refused the					
		ated that there should be a					
	_	generates documenting	(4)				
	the reason for the blank	K on the eMAR.					
	On 4/14/2022 at 8:30 a	ı.m., an interview was		- 1			
	conducted with ASM (a						i I
1	member) #2, the direct	or of nursing. ASM #2		1			
		lated 3/1/2022-3/31/2022		-			ļ
		2 with the blanks on the					] [
I .	dates listed above and	4					
		was not in the building or edication. ASM #2 stated					
	that there should be init						[
		efused the medication or					j i
	did not receive it. ASM						
I .		or documentation on the					
		ay whether it was refused,					
		d on the practice that they					
		by documenting it on the					
		that the record was not					
		taff were not completing					
t	he documentation.						
	The facility policy "Admi All Medications" dated 0	nIstration Procedures for 09/2018 documented in					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	4		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING				C 4/14/2022
	PROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		38	TREET ADDRESS, CITY, STATE, ZIP CODE 80 MILLWOOD AVENUE /INCHESTER, VA 22601	1	47 1412-022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	part, "After administration colored remain), and do the MAR (medication a	ration, return to cart, ntainer (if multi-dose and cument administration in administration record) or istration record) and the	F	842			
	#2, the director of nurs regional nurse consulta the findings.	ximately 8:35 a.m., ASM lng and ASM #4, the ant were made aware of was provided prior to exit.					
F 880 SS=D	Infection Prevention & CFR(s): 483.80(a)(1)(2) §483.80 Infection Control The facility must established infection prevention and designed to provide a second	Control )(4)(e)(f) rol ish and maintain an d control program	F	380			
	comfortable environment development and transing diseases and infections §483.80(a) Infection preprogram.  The facility must established.	nt and to help prevent the mission of communicable				-   -	
	reporting, investigating, and communicable dise staff, volunteers, visitors providing services under arrangement based upo	, and other individuals			F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT			TRUCTION	(X3) DATE	J. 0936-0397 SURVEY PLETED
			A. BOILDI					С
		495142	B. WING_				1	/14/2022
NAME OF P	PROVIDER OR SUPPLIER			ST	REET	ADDRESS, CITY, STATE, ZIP CODE		
EVERGRI	EEN HEALTH AND REHA	В	ĺ	36	O MIL	LWOOD AVENUE		
				W	INCH	ESTER, VA 22601		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION;	ID PREFIX TAG	<		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
			1	,	1.)	RN #2 was educated on		
F 880	Continued From page		F 8	80		appropriate use of PPE durin	g	
	accepted national star	ndards;	İ			medication administration pa	_	
	C402 00/a\/2\\\\	ahaadaada	1			on 4/13/22. The DON/desig		
		standards, policies, and gram, which must include,				_	Hee	
	but are not limited to:	gram, watch must melude,				has performed a root cause	_	
		апсе designed to identify	ļ			analysis with the assistance of		
	possible communicabl	e diseases or				the Infection Preventionist, C	QAPI	<i>'</i>
i	infections before they	can spread to other				team and governing body. Th	ne	
}	persons in the facility;	manifela invidente es				root cause analysis included	a İ	
	(ii) When and to whom communicable disease	or infections should be				review of the facility's curren	ıt	
	reported:	o il illicoloris official be				infection control policies and	- 1	
	(iii) Standard and trans	smission-based precautions				procedures, including guidan		
1		ent spread of infections;						
		ation should be used for a				from the CDC (Center for Dis	ease	
	resident; including but (A) The type and durat			ı		Control)'s "Recommended		
		fectious agent or organism				practices for preventing		
	involved, and					bloodborne pathogens		
	(B) A requirement that	the isolation should be the				transmission during blood	1	
T I	-	e for the resident under the				glucose monitoring and insul	in	i
	circumstances.					administration in healthcare		
	(v) The circumstances	under which the facility es with a communicable				settings". The analysis show	,,	
	disease or infected skir					the root cause to be that RN		
1	contact with residents of					*	_	
	contact will transmit the					did not typically pass medica	tion	
		rocedures to be followed				as she worked in the MDS		
	by staff involved in dire	ct resident contact.				department and lacked		
- 1,	8483 80(a)(4) A system	for recording incidents		Ì		education on PPE use during	a	
	identified under the faci					medication pass administrati	on.	
	corrective actions taken	,				The facility pharmacy policy i		
		-				injectable medications has be		i
	§483.80(e) Linens.					reviewed and does include th		
	Personnel must handle, transport linens so as to						10	
	transport linens so as to infection,	preventine spread of				use of gloves during insulin		
						administration. Licensed nur	ses	
M CMS-25876	02-99) Previous Versions Obsole	te Event IO; JV0T11		Facility	u Ir	including those that do not		40 - 4
(		STORE ID, WYOT IT		- arang	, IL .	ii continuatio	n sneet Pa	ge 104 of 109

	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DAT	(X3) DATE SURVEY COMPLETED	
		495142	B, WING	B. WING		C	
NAM	OF PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 04	4/14/2022
EVE	RGREEN HEALTH AND REHA	В		3	180 MILLWOOD AVENUE		
			<del></del>		WINCHESTER, VA 22601		
(X4 PRE TA	FIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F	IPCP and update their This REQUIREMENT by: Based on observation document review and was determined the fa infection control practic in the medication adm Resident #16.  The findings include: The facility staff failed administering two insu #16 (R16).  On the most recent MD assessment, a quarterl ARD (assessment refe the resident scored a 3 (brief Interview for men the resident is severely making daily decisions.  The physician orders d documented, "Levemir insulin used to treat per dlabetes) (1) 100 UNIT units subcutaneously in (diabetes mellitus)." The	iew. It an annual review of its program, as necessary. Is not met as evidenced and the staff interview, facility clinical record review, it cility staff failed to follow ces for one of six residents inistration observation,  It o wear gloves when the ininjections to Resident and the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the staff of the morning for DM to physician order dated and the pole with type 1 and 2 the morning for DM to physician order dated the morning for DM to physician order dated the morning of the pole with type 1 and 2 the pole with type 1 and 2 the morning for DM to physician order dated the morning for DM to physician order dated the morning of the physician order dated the pole with type 1 and 2 the pole with type	F	880	receive a medication pass competency observation which will include an evaluation of infection control practices duri injections.  An infection prevention and intervention plan consistent withe requirements of 42 CFR 483.80 has been implemented for all facility residents. The Local Health District has been contacted and has been asked assist regarding infection contipractices. The Local Health District has been given immediate access to the facility for onsite inspections to ensur the facility's compliance with federal long term care participation requirements for Medicare/Medicaid programs.  3.) The Director of Nursing/design has educated all licensed staff regarding medication administration and required Play with medication administration A competency was completed facility licensed staff and was validated by the RNC. Facility	th to rol y e ee	
	3/3/2022, documented, insulin used to treat per diabetes)(2) FlexPen So UNIT/ML; inject 5 units	Novolog (a short acting ple with type 1 and 2 plution Pen-injector 100			A competency was completed facility licensed staff and was	for	

CENTE	13 FOR WEDICARE &	VIEDICAID SERVICES				OWR M	<i>O.</i> 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION		SURVEY PLETED
		495142	B. WING			1	C /14/2022
NAME OF P	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		_		3	80 MILLWOOD AVENUE		
EVERGRI	EEN HEALTH AND REHAI	3		Ιv	VINCHESTER, VA 22601		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		L	PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
	conducted on 4/13/202 (registered nurse) #2. insulin to R16. RN #2 in the syringe. RN #2 IRN#2 did not have glo administer the Levemi returned to the medica needle and used hand proceeded to review the She pulled the FlexPercart. She set the flexpercart. Not administration of either administration of either An interview was conducted. She set the flexpercart. She set the flexpercart. Not administration of either An interview was conducted. She she set the flexpercart. She set the flexpercart. Not administration of either administration of either An interview was conducted. She set the flexpercart. Not administration of either An interview was conducted. She she set the flexpercart. Not administration of either An interview was conducted. She she she she she she she she she she s	istration observation was 22 at 8:27 a.m. with RN RN #2 was administering drew up the Levemir insulin proceeded to R16's room. In the RN #2 was administering drew up the Levemir insulin proceeded to R16's room. In the R16's left arm. RN #2 was an interest of the sanitizer. RN #2 was an entired for Novolog. In out of the medication was for the 5 units. RN #2 was again no gloves on. When again no gloves on. When a was a finite was a finite with RN #2 on when giving an she had never worm injection. She stated she she drew blood.  Sected with RN #4, the staff entionist, on 4/13/2022 at when giving an insulin se wear gloves, RN #4	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/design 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 Prare used during Medication Administration pass. The Director of Nursing/designees 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 quarter basis.  Date of Compliance: 5/16/202	in older	
		olicy, "Insulin evidence documentation eves when administering					E2:
	_	•				ļ	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495142	B. WING		C
	PROVIDER OR SUPPLIER REEN HEALTH AND REHAI	В		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601	04/14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF CORRECTIO ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETION
F 947 SS=D	Healthcare Settings" of gloves during blood gliduring any other proces exposure to blood or but as Mills (administrative stadministrator, ASM #2, ASM #4, the regional rimade aware of the about at 5:15 p.m.  No further information was following website: https://medlineplus.govitml (2) This information was following website: https://medlineplus.govitml, Required In-Service TracFR(s): 483.95(g)(1)-(4) §483.95(g) Required inaides. In-service training must \$483.95(g)(1) Be sufficicontinuing competence be no less than 12 hour §483.95(g)(2) Include detraining and resident abs §483.95(g)(3) Address as \$483.95(g)(3) Addres	documented in part, "Wear ucose monitoring and edure that involves potential and fluids."  itaff member) #1, the , the director of nursing and nurse consultant, were every concern on 4/13/2022  was provided prior to exit.  is obtained from the  indruginfo/meds/a606012.h  is obtained from the  indruginfo/meds/a605013.h  anining for Nurse Aides  is ervice training for nurse  ent to ensure the of nurse aides, but must is per year.  ementia management use prevention training.  areas of weakness as es' performance reviews	F 94		

OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495142	8, WING				C 04/14/2022	
(EACH DEFICIENCY	B ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	38 W	PROVIDER'S PLAN OF CORREC  (EACH CORRECTIVE ACTION SHOW  CROSS-REFERENCED TO THE APPR  DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
to individuals with cog address the care of the This REQUIREMENT by: Based on staff intervier review, it was determined failed to ensure CNAs completed required and two of five CNA record. The facility staff failed the facility staff failed the facility staff failed the facility staff failed the facility staff failed the facility staff failed the facility staff failed the facility staff failed the facility staff failed to review the facility staff failed to review the facility staff failed to review the facility staff failed to review the facility staff failed to review the facility staff failed to review the facility staff failed to review the facility staff failed to review the failed to rev	eeds of residents as illity staff.  se aides providing services nitive impairments, also e cognitively impaired. is not met as evidenced  ew and facility document ned that the facility staff (certified nursing aides) nual in-service training for reviews.  to ensure CNA #4 and CNA dementia training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.  i/1/99. A review of CNA veal evidence that the CNA ita training.	F	947	F947/VAC 5-371-260 Required In-Service 1  for Nurse Aides The facility has complete dementia training for CN and #6.  The Director of Nursing/o has conducted an audit of dementia training. Annual dementia training has be completed for all CNAs or employed by the facility. variances found have been corrected and all current employed CNAs have had dementia training.  The Director of Nursing/o has in-serviced nursing management and Human Resources staff on the importance of conducting CNA dementia training. The ducation included, but we limited to, procedure for conducting the annual detraining and identifying an CNA performance requiring additional in-service education in Service education in Service education in Service educational in-service educat	d annual designed from the des	ee al	
	., ASM (administrative dministrator) and ASM #2 were made aware of the			will perform an audit of a CNA dementia training we 6 weeks and then monthl	nnual eekly fo	or	

PRINTED: 04/22/2022 FORM APPROVED

		MEDIOAID GERVICES				OMB N	<u>IO. 0938-03</u> 91
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495142	B. WING				C 4/14/2022
	ROVIDER OR SUPPLIER EEN HEALTH AND REHAI	В		3	STREET ADDRESS, CITY, STATE, ZIP CODE 180 MILLWOOD AVENUE MINCHESTER, VA 22601	1 04	4/14/2022
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 947	Training Program* doc in-services: f. include t management*	f, "Nurse Aide In-Service cumented, "4. Annual	F	947	reviews are completed, and is service education is provided. The Director of Nursing/design 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 lequarterly basis.  5. Date of Compliance: 5/16/20	l. gnee or e s. th ast a	
				- 1			

		27	