PRINTED: 06/08/2023 FORM APPROVED OMB NO. 0938-0391

IAME OF P			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
AME OF P	495142 B. WING				the below the section.	1	R-C 05/30/2023	
NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHABILITATION CENTER				STREET ADDRESS, CIT 380 MILLWOOD AVEN WINCHESTER, VA	NUE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	IDER'S PLAN OF CORRECTION ORRECTIVE ACTION SHOULD BI FERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
{F 000}	standard survey cond 4/21/23 and 4/24/23 t conducted 5/30/23. C compliance with 42 C Term Care Requirement investigated during the The census in this 17	dicare/Medicaid revisit to the flucted 4/20/23 through hrough 4/25/23, was orrections are required for FR Part 483 Federal Long ents. No complaints were e survey.	{F 0	respectfully	Correction is submitted as compliance.			
F 607 SS=D	consisted of 7 current Develop/Implement A CFR(s): 483.12(b)(1)- §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95, §483.12(b)(4) Establis QAPI program require §483.12(b)(5) Ensure occurring in federally-facilities in accordance Act. The policies and	resident reviews. buse/Neglect Policies c(5)(ii)(iii) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures the allegations, and training as required at sh coordination with the ed under §483.75.	F6	allegation survey ag Protective 2. All res have the by the all The facili interview residents or greate and negl residents assessm assessin symptom allegation that are in abuse will addresses.	submitted for of abuse to State lency and Adult e Services. sidents of the facility potential to be affect leged deficient practic ity will conduct ity with all interview-at is with a BIMS score of er screening for abuse ect. Non-interviewab is will have skin ments performed ing for signs and ins of abuse. Any ins of abuse and negle identified in the audit ill be immediately ed in accordance with ity abuse and neglect	ce. ple f 8 e lle ect for		
SS=D	investigated during the The census in this 17 142 at the time of the consisted of 7 current Develop/Implement A CFR(s): 483.12(b)(1)-\$483.12(b) The facilitimplement written pol \$483.12(b)(1) Prohibineglect, and exploitat misappropriation of results of investigate any successful success	e survey. 61 certified bed facility was survey. The survey sample tresident reviews. buse/Neglect Policies (5)(ii)(iii) y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures that allegations, and training as required at sh coordination with the ed under §483.75. reporting of crimes funded long-term care e with section 1150B of the procedures must include		allegation survey ag Protective 2. All res have the by the all The facili interview residents or greate and negl residents assessm assessin symptom allegation that are i abuse wi addresse the facilit policy.	of abuse to State ency and Adult e Services. sidents of the facility potential to be affect leged deficient practicity will conduct where with all interview-at with a BIMS score of screening for abuse ect. Non-interviewable will have skin ments performed ag for signs and ans of abuse. Any ans of abuse and neglicity in accordance with each in accordance with	ce. ple f 8 e lle ect for		

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.

Facility ID: VA0218

13 mu 2023

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		405442	B. WING			R-C			
		495142	B. WING	,		05/3			
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
EVEDOR	EEN HEALTH AND REHA	BII ITATION CENTED			380 MILLWOOD AVENUE				
EVERGR	EEN NEALTH AND KENA	BEHATION CENTER		'	WINCHESTER, VA 22601				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 607	employee rights, as of (3) of the Act. §483.12(b)(5)(iii) Pro retaliation, as defined (2) of the Act. This REQUIREMENT by: Based on staff intervively, and clinical refailed to implement the allegation of abuse to one of seven resident Resident #107. The findings include: For Resident #107 (Resident #107) The findings include: For Resident #107 (Resident #107) The findings include: For Resident #107 (Resident #107) Bigging includes For Resident #107 (Resident #107) The findings include: For Resident #107 (Resident #107) The findings include: For Resident #107 (Resident #107) Admission assessment reference date) of 3/3 being severely impair decisions, having scould behavior disorders. A review of a document was admitted diagnoses including to behavior disorders. A review of a document was admitted in part: "5/22 conversation with CN assistants) [#1 and #2 male resident receiving was very agitated, ho	chibiting and preventing at section 1150B(d) whibiting and preventing at section 1150B(d)(1) and are is not met as evidenced siew, facility document ecord review, the facility staff abuse policy to report an attention the State Agency (SA), for its in the survey sample, and the survey sample, and the state Agency (SA) and the survey attention of a section of a sectio	F	607	3. All current staff will be educated on abuse and abuse reporting policy. All new employees will be provided with this training upon hire. All agency staff will also be provided with this education during the facility orientation prior to starting work at the facility. 4. The NHA or Designee will conduct interviews to validate understanding of reporting guidelines and investigate allegation of abuse 3x/week for 4 weeks. All allegations of abuse/neglect reported to the State Agency will be audited to ensure the abuse policy was implemented. The NHA/Designee will identify any trends or patterns and educate as needed. All findings will be discussed with the QAPI committee at least quarterly. 5. Date of Compliance: 6/19/2023				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
					R-C	
	495142	B. WING	www.man.com.man.com.man.com.man.com.man.com.man.com.man.com.man.com.man.com.man.com.man.com.man.com.man.com.ma	0:	5/30/2023	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
EVERGREEN HEALTH AND REHAL	BII ITATION CENTED		380 MILLWOOD AVENUE			
EAFKOVERILIEVELLI VIIO VELIVOLI OFFICE			WINCHESTER, VA 22601			
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE	(X5) COMPLETION DATE	
entered the shower ro [LPN #1] that this resis shower and her respo to get a shower'[LPN she would hold him do him[LPN #1] procee the arms, while reside [CNA #2] backed away not assist." A request to review all as reported to the SA requested. A review of information related to outlined in the 5/22/23 On 5/30/23 at 2:12 p.r. staff member) #1, the interviewed. She state came to her and told him a shower. She state came to her and told him a shower. She stated explanation as to why allegation immediately stated LPN #1 has beet time," and R107 can be She stated R107 frequerefuses medications, to She stated LPN #1 can take his medicine and physical care for him. believe that abuse occurroid the report to the report it." She stated sthe level of needing to	rse) #1, the unit manager)] rom[CNA #2] informed dent did not want to take a rse was that 'he was going N #1] informed [R107] that rown while the CNAs bathed ded to hold patient down at rnt continued to resist ry from this action and did I facility synopses of events since the last survey were f these files revealed no the allegation of abuse document from RN #1. m., ASM (administrative administrator, was at that on 5/23/23, CNA #2 rer about the incident where R107 down while giving ated CNA #2 told her the roximately two weeks prior I CNA #2 did not provide an she did not report this r after it happened. She en R107's nurse for "a long re aggressive and difficult. rently is aggressive and/or reatments, and bathing. In often convince R107 to to let the staff provide She stated she did not	F	607			

AND DI AN OF CORRECTION IN INDESTRUCTION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495142	B. WING			R-C 05/30/2023	
	ROVIDER OR SUPPLIER	BILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601		1 00,	0012020
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BI	(X5) COMPLETION DATE	
F 607	required to report all a SA, she stated: "Yes, On 5/30/23 at 3:29 p. nursing, was interview made the report of the CNA #2 failed to repo ASM #2 provided a fill evidence of the investabuse, including state employees. She state allegations of abuse simmediately. CNA #2 was not avail time of the survey. On 5/30/23 at 4:15 p. were informed of thesility "The facility is commit operationalizing policiidentification, investabuseEach covered reporter shall report the events that cause in serious bodily injury Agency and adult pro No further information Reporting of Alleged N CFR(s): 483.12(b)(5)(5)(5)(5)(5)(5)(5)(5)(5)(5)(5)(5)(5)	res." When asked if she is allegations of abuse to the I am." m., ASM #2, the director of wed and stated after CNA #2 and alleged abuse of R107, ret to work for three days. The containing credible at a containing credible at a containing the at should be reported able for interview during the first and a small procedures for individual/mandated and reporting of I individual/mandated and later than 24 hours if the suspicion do not result yout the State Survey tective services." In was provided prior to exit. Violations		607			
	must:						

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495142	B. WING			R-C 05/30/2023	
NAME OF P	ROVIDER OR SUPPLIER	1,00.12	1	5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 05	13012023
				ŀ	880 MILLWOOD AVENUE		
EVERGREEN HEALTH AND REHABILITATION CENTER					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
F 609	involving abuse, neglimistreatment, includir source and misappropare reported immedia hours after the allegat that cause the allegat serious bodily injury, the events that cause abuse and do not resist the administrator of the officials (including to the administrator of the administrator of the administrator of the officials (including to the administrator of the	that all alleged violations ect, exploitation or go injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in or not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and ses where state law provides elaw through established the results of all administrator or his or her ative and to other officials in the law, including to the State to 5 working days of the eged violation is verified elaction must be taken. Is not met as evidenced ew, facility document cord review, the facility staff gation of abuse to the State of seven residents in the ent #107.	F	609	1. Report submitted for allegation of abuse to State survey agency and Adult Protective Services. 2. All residents of the facility have the potential to be affected by the alleged deficient practice. The facility will conduct interviews for all interview-able residents with a BIMS score of 8 or greater screening for abuse and neglect. Non-interview-able residents will have skin assessments performed assessing for signs and symptoms of abuse. Any allegations of abuse and neglect that are identified in the audit for abuse will be immediately addressed in accordance with the facility abuse and neglect policy.		
	On the most recent M	DS (minimum data set), an					

A. BUILDING R-C 495142 B. WING 05/30/2023 NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHABILITATION CENTER A. BUILDING R-C 05/30/2023		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE EVERGREEN HEALTH AND REHABILITATION CENTER	i .	
EVERGREEN HEALTH AND REHABILITATION CENTER 380 MILLWOOD AVENUE)23	
EVERGREEN HEALTH AND REHABILITATION CENTER		
WINCHESTER, VA 22601		
	(X5) IPLETION DATE	
F 609 Continued From page 5 admission assessment with an ARD (assessment reference date) of 3/30/23, R107 was coded as being severely impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). The resident was admitted to the facility with diagnoses including dementia with mood and behavior disorders. A review of a document written by RN (registered nurse) #1, the staff development coordinator, revealed, in part: "5/22/23While engaging in conversation with CNAs (cartified nursing assistants) [#1 and #2]. I was informed of .a. male resident receiving a showerThis resident was atmempting to de-escalate the situation, I,ENN (licensed practical nurse) #1, the unit manager) entered the shower room[CNA #2]informed [LPN #1] that this resident did not want to take a shower and her response was that he was going to get a shower[LPN #1] informed [R107] that she would hold him down while the CNAs bathed him[LPN #1] proceeded to hold patient down at the arms, while resident continued to resist [CNA #2] backed away from this action and did not assist." A request to review all facility synopses of events as reported to the SA since the last survey were requested. A review of these files revealed no information related to the allegation of abuse outlined in the \$5/22/23 document from RN #1. On 5/30/23 at 2:12 p.m., ASM (administrative staff member) #1, the administrator, was interviewed. She stated that on \$5/23/23, CNA #2 came to her and told her about the incident where LP #1 #1 alleged to hold paltient town while giving		

A95142 NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED			
NAME OF PROVIDER OR SUPPLIER EVERGREEN HEALTH AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 380 MILLWOOD AVENUE WINCHESTER, VA 22601 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 him a shower. She stated CNA #2 told her the		B WING				i	
EVERGREEN HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 him a shower. She stated CNA #2 told her the 1380 MILLWOOD AVENUE WINCHESTER, VA 22601 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY DEFICIENCY COMPLE DATE OF CROSS-REFERENCED TO THE APPROPRIATE DATE OF		*****	493142			05/	30/2023
EVERGREEN HEALTH AND REHABILITATION CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 him a shower. She stated CNA #2 told her the	IME OF PROVIDER OR SUPPLIER			1			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 6 him a shower. She stated CNA #2 told her the	EVERGREEN HEALTH AND REHABILITATION CENTER						
him a shower. She stated CNA #2 told her the	PREFIX (EACH DEFICIENCY	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BY REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI			(X5) COMPLETION DATE		
to 5/23/23. She stated CNA #2 refused to provide a written statement. She stated CNA #2 and LPN #1 have a history of workplace conflict, and that LPN #1 had spoken to CNA #2 about concerns with her performance just prior to 5/23/23. She stated CNA #2 did not provide an explanation as to why she did not report this allegation immediately after it happened. She stated LPN #1 has been R107's nurse for "a long time," and R107 can be aggressive and difficult. She stated R107 frequently is aggressive and/or refuses medications, treatments, and bathing. She stated LPN #1 can often convince R107 to take his medicine and to let the staff provide physical care for him. She stated she did not believe that abuse occurred. When asked to provide the report to the SA, she stated: "I did not report it." She stated she was told it did not rise to the level of needing to be reported. When asked if this report by CNA #2 was an allegation of abuse, she stated: "Yes." When asked if she is required to report all allegations of abuse to the SA, she stated: "Yes," when asked if she is required to report all allegations of abuse, including statements from other employees. She stated she is ware that allegation of abuse, including statements from other employees. She stated she is aware that allegations of abuse should be reported immediately. CNA #2 was not available for interview during the time of the survey. On 5/30/23 at 4:15 p.m., ASM #1 and ASM #2 were informed of these concerns.	him a shower. She staincident occurred app to 5/23/23. She stated a written statement. She stated a written statement. She stated a written statement. She stated CNA #2 did not to why she did not reprimmediately after it has been R107's nursh R107 can be aggress R107 frequently is aggmedications, treatment LPN #1 can often conmedicine and to let the for him. She stated shoccurred. When asked SA, she stated: "I did she was told it did not to be reported. When #2 was an allegation of When asked if she is allegations of abuse to am." On 5/30/23 at 3:29 p.r. nursing, was interview containing credible evinto the allegation of a from other employees that allegations of abuse mediately. CNA #2 was not availatime of the survey. On 5/30/23 at 4:15 p.r.	F	ted CNA #2 told her the roximately two weeks prior CNA #2 refused to provide the stated CNA #2 and LPN orkplace conflict, and that CNA #2 about concerns ust prior to 5/23/23. She provide an explanation as ort this allegation ppened. She stated LPN #1 or a long time," and we and difficult. She stated pressive and/or refuses ts, and bathing. She stated prior a long time we are did not believe that abuse a told provide the report to the not report it." She stated prise to the level of needing asked if this report by CNA and fabuse, she stated: "Yes." equired to report all to the SA, she stated: "Yes, I had as the stated with the she should be reported with the she should be reported with the she was a	F 609	DEFICIENCY)		

	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER:		l ·	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			1			R-C			
		495142	B. WING _	·		05/	30/2023		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE				
EVERGRE	EN HEALTH AND REHA	BILITATION CENTER		380 MILLWOOD AVENUE					
			WINCHESTER, VA 22601 ID PROVIDER'S PLAN OF CORRECTION (
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 609	Continued From page A review of the facility	policy revealed, in part:	F 6	609					
	operationalizing polici	tted to developing and ies and procedures for tigation, and reporting of							
	the events that cause	not later than 24 hours if the suspicion do not result							
	Agency and adult pro								
	No further information	n was provided prior to exit.							