STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495142	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Health and Rehabilitation Center	380 Millwood Avenue Winchester, VA 22601

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement its policy to report an allegation of abuse for one of eight residents in the survey sample, Resident #8.The findings include: For Resident #8 (R8), the facility staff failed to implement its policy to report an allegation of abuse related to a verbal altercation between R8 and Resident #3 (R3) on 5/2/26.A review of R3's clinical record revealed the following progress note dated 5/2/26: Nursing Note [Resident #3] walked on his 3 prong cane down to [R8's] room and began arguing and cursing at [R8] because he was yelling earlier in the day. This note was written by LPN (licensed practical nurse) #1.Further review of R8's and R3's clinical records and of facility documents revealed no evidence that this incident was reported to management or to the State Agency (SA) as an allegation abuse.A review of the facility policy, Abuse Investigation and Reporting, revealed, in part: All reports of resident abuse.shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management.If an incident or suspected incident of resident abuse.is reported, the Administrator/designee will assign the investigation to an appropriate individual.All alleged violations involving abuse.will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The stated licensing/certification agency responsible for surveying/licensing the facility.On 5/5/26 at 2:30 p.m., LPN #1 was interviewed. She stated that R8 yells loudly and frequently, and that he can be heard all up and down the hallway. She stated she discovered after the altercation between R8 and R3 that R8 had actually been yelling for most of the time the previous evening and night. She stated that she heard R3 yelling and walked to R8's room to see what was happening. She found R3 standing in R8's doorway initially, then eventually walking further into the room closer to where R8 was sitting on his bed. She explained that R8 was not able to stand or walk on his own. She stated R3 and R8 were engaged in a heated argument and that R3 was yelling and cursing at R8. She explained that R8 must have been irritated. She stated she immediately separated the residents and she wrote a note in R3's clinical record about what she witnessed. She stated that in hindsight, she sees that this was potential verbal abuse. She added that she reported this incident to a supervisor but could not remember when she reported or to whom she reported it.On 5/5/26 at 2:28 p.m., LPN #2 was interviewed. She confirmed that if she observed one resident yelling and cursing at another resident, the verbal altercation could be considered verbal abuse and should be immediately reported for the overall safety of residents.On 5/6/26 at 12:11 p.m., the Administrator was interviewed. He stated that when he heard about the incident between R3 and R8 from LPN #1, he was not certain how accurate her account was. He stated he asked LPN #1 if she had reported this incident to the weekend supervisor, and LPN #1 indicated that she had. However, the weekend supervisor denied ever learning about the incident from LPN #1. The Administrator stated that this information should have been conveyed to him, and this definitely is an allegation of verbal abuse that should have been reported to the SA and investigated.No additional information was provided prior to exit.

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview, clinical record review, and facility document review, the facility staff failed to report an allegation of abuse for one of eight residents in the survey sample, Resident #8.The findings include:For Resident #8 (R8), the facility staff failed to report an allegation of abuse related to a verbal altercation between R8 and Resident #3 (R3) on 5/2/26.A review of R3's clinical record revealed the following progress note dated 5/2/26: Nursing Note [Resident #3] walked on his 3 prong cane down to [R8's] room and began arguing and cursing at [R8] because he was yelling earlier in the day. This note was written by LPN (licensed practical nurse) #1.Further review of R8's and R3's clinical records and of facility documents revealed no evidence that this incident was reported to management or to the State Agency (SA) as an allegation abuse.On 5/5/26 at 2:30 p.m., LPN #1 was interviewed. She stated that R8 yells loudly and frequently, and that he can be heard all up and down the hallway. She stated she discovered after the altercation between R8 and R3 that R8 had actually been yelling for most of the time the previous evening and night. She stated that she heard R3 yelling and walked to R8's room to see what was happening. She found R3 standing in R8's doorway initially, then eventually walking further into the room closer to where R8 was sitting on his bed. She explained that R8 was not able to stand or walk on his own. She stated R3 and R8 were engaged in a heated argument and that R3 was yelling and cursing at R8. She explained that R8 must have been irritated. She stated she immediately separated the residents and she wrote a note in R3's clinical record about what she witnessed. She stated that in hindsight, she sees that this was potential verbal abuse. She added that she reported this incident to a supervisor but could not remember when she reported or to whom she reported it.On 5/5/26 at 2:28 p.m., LPN #2 was interviewed. She confirmed that if she observed one resident yelling and cursing at another resident, the verbal altercation could be considered verbal abuse and should be immediately reported for the overall safety of residents.On 5/6/26 at 12:11 p.m., the Administrator was interviewed. He stated that when he heard about the incident between R3 and R8 from LPN #1, he was not certain how accurate her account was. He stated he asked LPN #1 if she had reported this incident to the weekend supervisor, and LPN #1 indicated that she had. However, the weekend supervisor denied ever learning about the incident from LPN #1. The Administrator stated that this information should have been conveyed to him, and this definitely is an allegation of verbal abuse that should have been reported to the SA and investigated.A review of the facility policy, Abuse Investigation and Reporting, revealed, in part: All reports of resident abuse.shall be promptly reported to local, state, and federal agencies and thoroughly investigated by facility management.If an incident or suspected incident of resident abuse.is reported, the Administrator/designee will assign the investigation to an appropriate individual.All alleged violations involving abuse.will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: The stated licensing/certification agency responsible for surveying/licensing the facility.No additional information was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for one of eight residents in the survey sample, Resident #6.The findings include:For Resident #6 (R6), the facility staff failed to review and revise his care plan following two episodes of intoxication in [DATE].R6 was admitted to the facility on [DATE]. One of the resident's diagnoses on admission was alcohol abuse.A review of R6's clinical record revealed the following progress notes: [DATE] 22:54 (10:54 p.m.) Resident came down from upstairs visually intoxicated. Writer witnessed resident pull a bottle out from inside his pants in the groin area. Resident slurring his speech, cursing at staff and talking to self. MOD (manager on duty) notified. Asked to get a set of vitals (resident refused) and write a note. NP (nurse practitioner) made aware through communication book. [DATE] 14:30 (2:30 p.m.) NP Note Staff reported intoxication.Alcohol/Caffeine/HydrationAlcohol: current use. Staff reported patient acted intoxicated on [DATE] with smell of alcohol. Previously noted acting giggly with reports from another resident that alcohol is being brought to him at the facility.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED: Staff reported patient acted intoxicated on [DATE] with smell of alcohol noted. History of ongoing alcohol abuse with previous reports of alcohol being brought to him at the facility. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg (milligrams) by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol. [DATE] 13:30 (1:30 p.m.) NP Note History of Present Illness [R6], [AGE] years old male, is seen today for order review. The patient was found intoxicated yesterday, passed out with a vodka bottle under his chair in a water bottle. There are no changes to his medications at this time.Alcohol/Caffeine/Hydration Alcohol: current use. Patient found intoxicated yesterday, passed out with vodka under chair in water bottle. Staff previously noted patient acting giggly and reports from another resident that alcohol is being brought to him at the facility. Patient placed in book for supervised leave only due to alcohol use.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED: Patient found intoxicated yesterday, passed out with vodka bottle under chair in water bottle. Patient placed in book for supervised leave only due to alcohol use. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol. [DATE] 13:00 1:00 p.m. NP Note History of Present Illness [R6], [AGE] years old male, is seen today for recertification visit. The patient has no acute complaints at this time. Conducted a 30-minute counseling session regarding Alcohol Abuse. Reviewed the incidents on 03/09 and 03/12 where the patient was found intoxicated. Discussed how alcohol use directly interferes with his hypertension management (BP [blood pressure] 147/92) and significantly increases his risk for are current stroke/CVA (cerebrovascular accident) and aspiration due to his chronic dysphagia (difficulty swallowing). Previously, the patient was seen on [DATE] when he was found intoxicated, passed out with a vodka bottle under his chair in a water bottle. Prior to that, on [DATE], staff reported that the patient acted intoxicated with smell of alcohol noted.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED Patient found intoxicated on [DATE], passed out with vodka bottle under chair in water bottle. Patient placed in book for supervised leave only due to alcohol use. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol.A review of R6's care plan dated [DATE] revealed, in part: Hx (history) of alcoholism. [R6] is at risk for complications due to a history of alcoholism.Administer medications as ordered.Observe resident for any signs and symptoms of intoxication or withdrawal from alcohol such as tremors, nausea/vomiting (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(severe), sweating and notify [provider] as indicated.Vitals as needed. This review revealed no information related to the [DATE] or [DATE] episodes of intoxication.On [DATE] at 2:30 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated she works almost exclusively on R6's unit and knows the resident well. She described R6 as a drinker, adding that he most often drinks on the weekends when there is very little management staff in the building. She stated that she does not often document R6's intoxication symptoms because she feels like she can't. She described R6's behavior under the influence of alcohol as sexually seeking, loud, and vulgar. She stated she believed management has had some conversations with R6 about his behaviors, but she was not certain.On [DATE] at 4:04 p.m., LPN #3 was interviewed. She stated that there was group of former and current residents, some of whom are deceased , who frequently use alcohol in the facility. She stated she suspects some of the residents are allowed to leave the facility and bring the alcohol back for other residents, but she has no evidence to verify this. She stated she frequently smells alcohol on R6, and usually these episodes correspond to when the resident has visitors from the community. She stated she was working on [DATE] when R6 was intoxicated and pulled the bottle of liquor from inside the front of his pants. She stated she alerted the weekend supervisor, who did not go to the unit to help her. She explained the supervisor told her to simply take his vital signs and write a note. She added that R6 would not allow her to take his vital signs.On [DATE] at 4:15 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated she smells pervasive alcohol on R6 every once in a while. She explained that she did not know where R6 was getting his alcohol.On [DATE] at 1:15 p.m., LPN #4 was interviewed. She stated that the purpose of a care plan is to instruct the staff on the best way to care for each resident, and to include the resident's needs and preferences in the plan of care. She stated the care plan includes the resident's diagnoses, orders, diets, and anything else that significantly impacts the resident's life at the facility. She stated that floor nurses do not have the ability to update a care plan, and that the unit manager is responsible for doing this. On [DATE] at 1:53 p.m., the Administrator, the Director of Nursing, and the Regional Nurse Consultant were informed of these concerns.A review of the facility policy, Comprehensive Person-Centered Care Planning, revealed, in part: The comprehensive care plan will incorporate identified problem areas, incorporate risk factors associated with identified problems.Aid in preventing or reducing declines in the resident's functional status and/or functional levels.Promote resident safety.The care Planning/Interdisciplinary Team is responsible for the review and updating of care plans.When there has been a significant change in the resident's condition.When the desired outcome is not met.No additional information was provided prior to exit.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide behavioral health services for one of eight residents in the survey sample, Resident #6.The findings include:For Resident #6 (R6), the facility staff failed to offer behavioral health services related to his substance use disorder (SUD) following two episodes of intoxication in [DATE].R6 was admitted to the facility on [DATE]. One of the resident's diagnoses on admission was alcohol abuse.A review of R6's clinical record revealed the following progress notes: [DATE] 22:54 (10:54 p.m.) Resident came down from upstairs visually intoxicated. Writer witnessed resident pull a bottle out from inside his pants in the groin area. Resident slurring his speech, cursing at staff and talking to self. MOD (manager on duty) notified. Asked to get a set of vitals (resident refused) and write a note. NP (nurse practitioner) made aware through communication book. [DATE] 14:30 (2:30 p.m.) NP Note Staff reported intoxication.Alcohol/Caffeine/HydrationAlcohol: current use. Staff reported patient acted intoxicated on [DATE] with smell of alcohol. Previously noted acting giggly with reports from another resident that alcohol is being brought to him at the facility.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED: Staff reported patient acted intoxicated on [DATE] with smell of alcohol noted. History of ongoing alcohol abuse with previous reports of alcohol being brought to him at the facility. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg (milligrams) by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol. [DATE] 13:30 (1:30 p.m.) NP Note History of Present Illness [R6], [AGE] years old male, is seen today for order review. The patient was found intoxicated yesterday, passed out with a vodka bottle under his chair in a water bottle. There are no changes to his medications at this time.Alcohol/Caffeine/Hydration Alcohol: current use. Patient found intoxicated yesterday, passed out with vodka under chair in water bottle. Staff previously noted patient acting giggly and reports from another resident that alcohol is being brought to him at the facility. Patient placed in book for supervised leave only due to alcohol use.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED: Patient found intoxicated yesterday, passed out with vodka bottle under chair in water bottle. Patient placed in book for supervised leave only due to alcohol use. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol. [DATE] 13:00 1:00 p.m. NP Note History of Present Illness [R6], [AGE] years old male, is seen today for recertification visit. The patient has no acute complaints at this time. Conducted a 30-minute counseling session regarding Alcohol Abuse. Reviewed the incidents on 03/09 and 03/12 where the patient was found intoxicated. Discussed how alcohol use directly interferes with his hypertension management (BP [blood pressure] 147/92) and significantly increases his risk for are current stroke/CVA (cerebrovascular accident) and aspiration due to his chronic dysphagia (difficulty swallowing). Previously, the patient was seen on [DATE] when he was found intoxicated, passed out with a vodka bottle under his chair in a water bottle. Prior to that, on [DATE], staff reported that the patient acted intoxicated with smell of alcohol noted.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED Patient found intoxicated on [DATE], passed out with vodka bottle under chair in water bottle. Patient placed in book for supervised leave only due to alcohol use. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol.A review of R6's clinical record revealed a social services quarterly assessment dated [DATE]. This assessment contained no information related to R6's two intoxication incidents in [DATE].Further review of R6's clinical record revealed no evidence of any type of investigation into how R6 obtained (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the alcohol which caused his two episodes of intoxication in [DATE].A review of R6's psychiatry NP notes revealed no evidence that R6 was seen by the provider between [DATE] and [DATE]. The facility provided no evidence that the psychiatry NP was aware of the two intoxication incidents in [DATE].A review of R6's care plan dated [DATE] revealed, in part: Hx (history) of alcoholism. [R6] is at risk for complications due to a history of alcoholism.Administer medications as ordered.Observe resident for any signs and symptoms of intoxication or withdrawal from alcohol such as tremors, nausea/vomiting (severe), sweating and notify [provider] as indicated.Vitals as needed.A review of R6's providers' orders revealed the following order dated [DATE]: Activity: May not have alcohol. There was no order related to the resident's requiring supervised leave of absences.On [DATE] at 2:30 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated she works almost exclusively on R6's unit and knows the resident well. She described R6 as a drinker, adding that he most often drinks on the weekends when there is very little management staff in the building. She stated that she does not often document R6's intoxication symptoms because she feels like she can't. She described R6's behavior under the influence of alcohol as sexually seeking, loud, and vulgar. She stated she believed management has had some conversations with R6 about his behaviors, but she was not certain.On [DATE] at 4:04 p.m., LPN #3 was interviewed. She stated that there was group of former and current residents, some of whom are deceased , who frequently use alcohol in the facility. She stated she suspects some of the residents are allowed to leave the facility and bring the alcohol back for other residents, but she has no evidence to verify this. She stated she frequently smells alcohol on R6, and usually these episodes correspond to when the resident has visitors from the community. She stated she was working on [DATE] when R6 was intoxicated and pulled the bottle of liquor from inside the front of his pants. She stated she alerted the weekend supervisor, who did not go to the unit to help her. She explained the supervisor told her to simply take his vital signs and write a note. She added that R6 would not allow her to take his vital signs.On [DATE] at 4:15 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated she smells pervasive alcohol on R6 every once in a while. She explained that she did not know where R6 was getting his alcohol.On [DATE] at 9:02 a.m., the Administrator stated that the facility currently employs a Director of Social Services, but they have had difficulty steadily employing a Social Services Assistant. He stated the large facility is a very heavy load for one Social Worker.On [DATE] at 9:40 a.m., NP #1 was interviewed. She stated that her understanding of the facility protocol for someone with a diagnosis of alcoholism and a current substance abuse issue is that the facility will restrict the resident's ability to leave the facility unsupervised. She explained that she is aware of past situations where residents leave the facility and return drunk. She stated: I don't know what they do. I have ordered specific things in the past, but I don't know what their policy is. She stated that she is uncertain about the wholistic approach the facility staff is taking to address SUD. She stated that soon after R6's admission, she attempted to test his urine and his blood for multiple substances, but the resident refused. She added that she doesn't know what options there are to address SUD in a long term care facility and that she has never had to deal with these kinds of issues before in this setting. She stated she believes R6's SUD is chronic and that he has no interest in stopping. She explained her experience is that R6 is continually trying to hide his behavior. She explained that alcohol can have a negative impact on several of R6's comorbidities including his heart arrhythmia, his risk of having another stroke, his high blood pressure, and his diabetes.On [DATE] at 11:35 a.m., the Director of Social Services was interviewed. He stated that he sometimes has a role in addressing a resident's SUD, but that most often, nursing takes the lead. He added that sometimes he is never even brought into the loop of a resident's SUD. He stated he had no knowledge of R6's alcohol use and that nothing related to R6's being intoxicated at the facility had ever been reported to him. He explained that the only psychological services the facility offers is medication related. He stated: We don't have any options for talk therapy of any kind. If someone is drinking, it is not really my call. It is up to the NPs. It is a medical issue.On [DATE] at 12:28 p.m., NP #1 stated she did not have any details to add about the (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	incident which she documented took place on [DATE] when R6 passed out. She stated she believed this happened during an activity and that the activities staff told her about it.On [DATE] at 12:53 p.m., the Director of Activities stated she was not aware of R6 ever passing out at an activity, that she had checked with her staff, and that none of her staff was aware of any such incident.On [DATE] at 1:53 p.m., the Administrator, the Director of Nursing, and the Regional Nurse Consultant were informed of these concerns.A review of the facility policy, Behavioral Health Services, revealed, in part: Residents will receive behavioral health services as needed to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care.Substance Use Disorder is defined as recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment such as health problems or disability.Behavioral health services are provided to residents as needed as part of the interdisciplinary, person-centered approach to care.Residents who exhibit signs of emotional/psychosocial distress will be offered services and support that address their individual needs and goals of care.A review of the facility policy, Substance Use Disorder, revealed, in part: The purpose of this policy is to identify patients/residents prior to admission and discharge processes as they relate to substance use disorder. To identify all appropriate diagnoses or specific services needed as they relate to substance abuse/use on addiction and to determine risk for relapse and the level of supervision needed.The facility will conduct a substance use disorder assessment of the patient/resident within 48-72 hours of admission to identify risk and put a plan of care in place.Social services will possibly have the patient/resident sign a contract upon admission and/or anytime during the patient's/resident's stay to alert the patient/resident that if the team feels that they are at risk for illicit drug use, then a search of their belongings may be warranted.The PCP (primary care physician) or NP will need to see patients/residents at risk and address concerns of relapse in their plan while collaboratively working with the interdisciplinary team.Social services will work on the possibilities of setting up support groups in collaboration with the Activities department to provide adequate support to the current population.Social services will work to get other support services, if possible, as added support for the residents.The nursing staff and social services department will provide education on relapse risk and prevention to provide adequate support.No additional information was provided prior to exit.

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide medically related social services for one of eight residents in the survey sample, Resident #6.The findings include:For Resident #6 (R6), the facility staff failed to offer medically related social services related to his substance use disorder (SUD) following two episodes of intoxication in [DATE].R6 was admitted to the facility on [DATE]. One of the resident's diagnoses on admission was alcohol abuse.A review of R6's clinical record revealed the following progress notes: [DATE] 22:54 (10:54 p.m.) Resident came down from upstairs visually intoxicated. Writer witnessed resident pull a bottle out from inside his pants in the groin area. Resident slurring his speech, cursing at staff and talking to self. MOD (manager on duty) notified. Asked to get a set of vitals (resident refused) and write a note. NP (nurse practitioner) made aware through communication book. [DATE] 14:30 (2:30 p.m.) NP Note Staff reported intoxication.Alcohol/Caffeine/HydrationAlcohol: current use. Staff reported patient acted intoxicated on [DATE] with smell of alcohol. Previously noted acting giggly with reports from another resident that alcohol is being brought to him at the facility.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED: Staff reported patient acted intoxicated on [DATE] with smell of alcohol noted. History of ongoing alcohol abuse with previous reports of alcohol being brought to him at the facility. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg (milligrams) by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol. [DATE] 13:30 (1:30 p.m.) NP Note History of Present Illness [R6], [AGE] years old male, is seen today for order review. The patient was found intoxicated yesterday, passed out with a vodka bottle under his chair in a water bottle. There are no changes to his medications at this time.Alcohol/Caffeine/Hydration Alcohol: current use. Patient found intoxicated yesterday, passed out with vodka under chair in water bottle. Staff previously noted patient acting giggly and reports from another resident that alcohol is being brought to him at the facility. Patient placed in book for supervised leave only due to alcohol use.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED: Patient found intoxicated yesterday, passed out with vodka bottle under chair in water bottle. Patient placed in book for supervised leave only due to alcohol use. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol. [DATE] 13:00 1:00 p.m. NP Note History of Present Illness [R6], [AGE] years old male, is seen today for recertification visit. The patient has no acute complaints at this time. Conducted a 30-minute counseling session regarding Alcohol Abuse. Reviewed the incidents on 03/09 and 03/12 where the patient was found intoxicated. Discussed how alcohol use directly interferes with his hypertension management (BP [blood pressure] 147/92) and significantly increases his risk for are current stroke/CVA (cerebrovascular accident) and aspiration due to his chronic dysphagia (difficulty swallowing). Previously, the patient was seen on [DATE] when he was found intoxicated, passed out with a vodka bottle under his chair in a water bottle. Prior to that, on [DATE], staff reported that the patient acted intoxicated with smell of alcohol noted.Assessment and Plan.ALCOHOL ABUSE, UNCOMPLICATED Patient found intoxicated on [DATE], passed out with vodka bottle under chair in water bottle. Patient placed in book for supervised leave only due to alcohol use. Continue vitamin support per active orders: thiamine (vitamin B1) 100 mg by mouth once daily, folic acid 1 mg by mouth once daily, and multivitamin with minerals 1 tablet by mouth once daily. Continue facility monitoring/supervision per protocol.A review of R6's clinical record revealed a social services quarterly assessment dated [DATE]. This assessment contained no information related to R6's two intoxication incidents in [DATE].Further review of R6's clinical record revealed no evidence of any type of investigation into how R6 obtained (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495142	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evergreen Health and Rehabilitation Center	380 Millwood Avenue Winchester, VA 22601

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the alcohol which caused his two episodes of intoxication in [DATE].A review of R6's psychiatry NP notes revealed no evidence that R6 was seen by the provider between [DATE] and [DATE]. The facility provided no evidence that the psychiatry NP was aware of the two intoxication incidents in [DATE].A review of R6's care plan dated [DATE] revealed, in part: Hx (history) of alcoholism. [R6] is at risk for complications due to a history of alcoholism.Administer medications as ordered.Observe resident for any signs and symptoms of intoxication or withdrawal from alcohol such as tremors, nausea/vomiting (severe), sweating and notify [provider] as indicated.Vitals as needed.On [DATE] at 2:30 p.m., LPN (licensed practical nurse) #2 was interviewed. She stated she works almost exclusively on R6's unit and knows the resident well. She described R6 as a drinker, adding that he most often drinks on the weekends when there is very little management staff in the building. She stated that she does not often document R6's intoxication symptoms because she feels like she can't. She described R6's behavior under the influence of alcohol as sexually seeking, loud, and vulgar. She stated she believed management has had some conversations with R6 about his behaviors, but she was not certain.On [DATE] at 4:04 p.m., LPN #3 was interviewed. She stated that there was group of former and current residents, some of whom are deceased , who frequently use alcohol in the facility. She stated she suspects some of the residents are allowed to leave the facility and bring the alcohol back for other residents, but she has no evidence to verify this. She stated she frequently smells alcohol on R6, and usually these episodes correspond to when the resident has visitors from the community. She stated she was working on [DATE] when R6 was intoxicated and pulled the bottle of liquor from inside the front of his pants. She stated she alerted the weekend supervisor, who did not go to the unit to help her. She explained the supervisor told her to simply take his vital signs and write a note. She added that R6 would not allow her to take his vital signs.On [DATE] at 4:15 p.m., CNA (certified nursing assistant) #1 was interviewed. She stated she smells pervasive alcohol on R6 every once in a while. She explained that she did not know where R6 was getting his alcohol.On [DATE] at 9:02 a.m., the Administrator stated that the facility currently employs a Director of Social Services, but they have had difficulty steadily employing a Social Services Assistant. He stated the large facility is a very heavy load for one Social Worker.On [DATE] at 11:35 a.m., the Director of Social Services was interviewed. He stated that he sometimes has a role in addressing a resident's SUD, but that most often, nursing talks the lead. He added that sometimes he is never even brought into the loop of a resident's SUD. He stated he had no knowledge of R6's alcohol use and that nothing related to R6's being intoxicated at the facility had ever been reported to him. He explained that the only psychological services the facility offers is medication related. He stated: We don't have any options for talk therapy of any kind. If someone is drinking, it is not really my call. It is up to the NPs. It is a medical issue.On [DATE] at 1:53 p.m., the Administrator, the Director of Nursing, and the Regional Nurse Consultant were informed of these concerns.A review of the facility policy, Substance Use Disorder, revealed, in part: The purpose of this policy is to identify patients/residents prior to admission and discharge processes as they relate to substance use disorder. To identify all appropriate diagnoses or specific services needed as they relate to substance abuse/use on addiction and to determine risk for relapse and the level of supervision needed.The facility will conduct a substance use disorder assessment of the patient/resident within 48-72 hours of admission to identify risk and put a plan of care in place.Social services will possibly have the patient/resident sign a contract upon admission and/or anytime during the patient's/resident's stay to alert the patient/resident that if the team feels that they are at risk for illicit drug use, then a search of their belongings may be warranted.The PCP (primary care physician) or NP will need to see patients/residents at risk and address concerns of relapse in their plan while collaboratively working with the interdisciplinary team.Social services will work on the possibilities of setting up support groups in collaboration with the Activities department to provide adequate support to the current population.Social services will work to get other support services, if possible, as added support for the residents.The nursing staff and social services department will provide education on relapse risk (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and prevention to provide adequate support.A review of the facility job description, Director of Social Services, revealed, in part: Responsible for providing medically related social work services so that each resident may attain or maintain the highest practicable level of physical, mental, and psychosocial well-being.Identifies cognitive impairments, signs of mood problems, and psychosocial needs and follows up as needed.Maintains accurate and timely documentation.Makes appropriate referrals to other consultants, community agencies, or Center departments to facilitate the resident's maximum use of resources and promote increased social functioningNo additional information was provided prior to exit.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of eight residents in the survey sample, Resident #2.The findings include:For Resident #2 (R2), the facility staff failed to maintain an accurate clinical record regarding the resident's alcohol use.On 5/5/26 at 11:22 a.m., R2 was observed lying on his right side in bed. He was awake and alert, and there was no odor of alcohol anywhere in the room.A review of R2's clinical record revealed the following Nurse Practitioner (NP) progress note dated 2/5/26: Visit Type: Follow Up Visit.Social History.Alcohol/Caffeine/Hydration.Strong odor of alcohol noted during assessment, consistent with ongoing alcohol use.Further review of R2's clinical record revealed the identical documentation regarding the odor of alcohol on the following dates: 3/3/26, 3/13/26, 3/17/26, 4/10/26, 4/15/26, 4/22/26, 4/29/26, and 5/1/26.On 5/6/26 at 9:40 a.m., Nurse Practitioner (NP) #1 was interviewed. She stated her practice utilizes a software the incorporates AI (artificial intelligence) into providers' notes. She stated she dictates a note regarding her observations, assessment, and plan for a resident as soon as the visit is complete. The software, aided by AI, pulls other information together from the resident's entire record and creates a note. She stated she does not go back to read the complete note or check it for accuracy because of the volume of residents she sees each day.On 5/6/26 at 11:57 a.m., NP #2 was interviewed. She stated she was responsible for all the notes related to R2. She explained that the software system for providers' notes used by her practice is relatively new and incorporates AI. She stated she dictates new information based on her visit with a resident and the software synchronizes the new information with historical information in the entire clinical record. She stated the software even pulls information from the resident's previous hospital stays and other historical documentation. She stated that she attempts to look over the new information she has dictated once the note is finished and that she has discovered inaccuracies from time to time. She stated it is very difficult to try to read the entire note when she has upwards of 25 residents to see in one day, especially when the residents have complicated social histories. She stated she had never smelled alcohol on R2 at any point in time and felt strongly this information came perhaps from a hospital note prior to R2's admission to the facility. She stated: This is not an accurate record for this resident.On 5/6/26 at 1:53 p.m., the Administrator, the Director of Nursing, and the Regional Nurse Consultant were informed of these concerns.No additional information was provided prior to exit.