STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495330	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Regional Medical Center	1017 George Washington Highway North Chesapeake, VA 23323

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. (continued on next page)

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

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, facility document review, and facility policy review, the facility failed to provide residents with advanced beneficiary notices, with enough information to make informed decisions, for 2 (Resident #45 and Resident #46) of 3 residents sampled for beneficiary notices. Findings included:An undated facility policy titled Skilled Nursing Facility (SNF) Notices of Non-Coverage specified delivery requirements included, Correct form must be given and properly completed. 1. An admission Record indicated the facility admitted Resident #45 on 01/11/2025. According to the admission Record, the resident had a medical history that included diagnoses of sequelae of cerebral infraction (stroke) and chronic respiratory failure with hypoxia (failure of the lungs to adequately exchange oxygen from the air to the bloodstream). A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/20/2025, revealed Resident #45 had a Brief Interview for Mental Status (BIMS) score of 8, which indicated the resident had moderate cognitive impairment. The MDS assessment also revealed Resident #45's end date of the most recent Medicare stay was on 03/20/2025. Resident #45's Care Plan Report included a focus area initiated 07/24/2025 that indicated the resident had impaired cognition or impaired thought process due to dementia. Interventions directed staff to communicate with the resident/family/caregivers regarding the resident's capabilities and needs. The Care Plan Report also included a focus area initiated on 01/19/2025 that indicated the resident had a communication problem related to aphasia, difficulty understanding others, and difficulty making decisions, making self-understood and had slurred speech. Interventions directed staff to monitor and document the resident's ability to express and comprehend language, memory reasoning ability, and problem-solving ability. A SNF Beneficiary Notification Review indicated Resident #45's Medicare Part A skilled services episode started on 01/11/2025, and their last covered day of Part A services was to end on 03/20/2025. The SNF Beneficiary Notification Review indicated the facility had initiated the discharge from Medicare Part A services when benefit days were not exhausted. A Notice of Medicare Non-Coverage [NOMNC]-CMS [Centers for Medicare & Medicaid Services]-10123-NOMNC form revealed the document was signed by Resident #45 on 03/14/2025. The document did not include what Medicare Part A services were to end. A Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN) CMS-10055 form revealed the document was signed by Resident #45 on 03/14/2025. The document indicated that, beginning on 03/20/2025, the resident may have to pay out of pocket for care. The form did not include the reason the care was no longer going to be provided, nor did it provide an estimate of the cost the resident may have to pay per day if they wished for services to continue. 2. An admission Record indicated the facility admitted Resident #46 on 11/01/2006 with a recent readmission on [DATE]. According to the admission Record, the resident had a medical history that included diagnoses of metabolic encephalopathy (condition when the brain does not receive adequate oxygen or nutrients) and hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body that affects the arm, leg or face) following cerebral infraction (stroke) affecting right dominant side. A five-day Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 07/02/2025, revealed Resident #46 had a Brief Interview of Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. The MDS assessment did not include an end date of the most recent Medicare stay. Resident #46's Care Plan Report included a focus area initiated 09/15/2024 that indicated the resident had a communication problem related to unclear speech, difficulty understanding others, and difficulty making their needs known. Interventions directed staff to ask yes/no questions if appropriate, use simple, brief, consistent words, and use alternate communication tools as needed. A SNF Beneficiary Notification Review indicated Resident #46's Medicare Part A skilled services episode started on 06/30/2025, and their last covered day of Part A services was to end on 07/30/2025. The SNF Beneficiary Notification Review indicated the facility had initiated the discharge from Medicare Part A when benefit days were not exhausted. The document also revealed a Skilled Nursing Facility [SNF] Advance Beneficiary Notice [ABN] of Non-Coverage (SNF-ABN Form CMS [Centers for Medicare & Medicaid Services] 10055) had not been provided to the resident. A Notice of Medicare Non-Coverage-CMS-10095 form indicated a verbal authorization was obtained from Resident #46 and the document was signed by staff on behalf of the resident on 07/28/2025. The document indicated the residents' services were to end on 07/30/2025 but did not indicate what Medicare Part A services were to end. During an interview on 09/16/2025 at 10:59 AM, the

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, record review, and facility policy review, the facility failed to provide incontinence care to 1 (Resident #12) of 3 sampled residents reviewed who were dependent on staff for assistance with activities of daily living (ADLs). Findings included:A policy titled, Activities of Daily Living (ADL), Supporting, revised 03/2018 revealed a section titled Policy Interpretation and Implementation that specified, 2. Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: c. Elimination (toileting). An admission Record indicated the facility admitted Resident #12 on 08/14/2025. The admission Record indicated diagnoses that included the need for assistance with personal care. An admission Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 08/21/2025, revealed Resident #12 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS also revealed Resident #12 had the ability to understand, to be understood, required substantial/moderate assistance of staff for toileting and personal hygiene, was not assessed to perform toilet transfers, and was always incontinent of bowel and bladder. A Care Plan Report, included a focus area revised 08/23/2025, that indicated the resident had ADL self-care performance deficits related to an unfamiliar environment, impaired mobility, and numerous medical issues. Interventions directed staff to encourage the use of the call bell to request assistance and for staff to help with ADL functions to keep the resident clean, dry, odor free, and neatly groomed. A concurrent observation and interview on 09/17/2025 at 9:40 AM revealed Resident #12 in their room seated upright in bed. A clock was observed on the wall. Resident #12 stated the resident turned their call light on around 7:00 AM that morning (09/17/2025), and when Certified Nursing Assistant (CNA) #3 responded to the call light, Resident #12 told CNA #3 that they needed incontinence care. Resident #12 stated CNA #3 told the resident that breakfast trays were about to come out, but that she would notify the assigned CNA, (CNA #6), that the resident needed incontinence care. CNA #6 then turned off the resident's call light and left the room. Resident #12 stated they received their breakfast, waited an unspecified time, then turned their call light back on. Resident #12 then said that after they put their call light back on, Licensed Practical Nurse (LPN) #5 answered the call light. The resident told LPN #5 that they needed incontinence care, and LPN #5 told the resident that the assigned CNA would be right there. Resident #12 stated that no one had changed their brief yet, and the resident had remained in a soiled brief since 7:00 AM that morning. During an interview on 09/17/2025 at 9:45 AM, CNA #6 stated she was familiar with Resident #12, and she provided nursing care to Resident #12 before. CNA #6 described Resident #12 as incontinent of bowel and bladder. CNA #6 stated she arrived at work that morning (09/17/2025) at 7:00 AM and provided Resident #12 with their breakfast tray around 7:40 AM or 7:45 AM, but that she had not been back to see the resident or provide any morning care yet. CNA #6 said she started her rounds for morning care about 45 minutes before, around 9:00 AM, and she was working her way towards Resident #12. When the surveyor shared that Resident #12 said they had been waiting for incontinence care since 7:00 AM, CNA #6 said no one told her that Resident #12 needed care, but she would continue to work her way towards Resident #12 and give the resident care as soon as she could. During an interview on 09/17/2025 at 9:50 AM, LPN #5 revealed she was about to enter a resident's room around 9:30 or 9:40 AM that morning (09/17/2025) and Resident #12's call light was illuminated. LPN #5 stated she went to Resident #12's room and asked the resident what they needed, and the resident said they needed incontinence care. LPN #5 stated that CNA #6 stuck her head out of another resident's room and said, Tell [the resident] I will be right there, so she told Resident #12 that the CNA would be right there. LPN #5 said that since CNA #6 said that she would be right there to help the resident, she did not tell CNA #6 that the resident said they needed incontinence care. During an interview on 09/17/2025 at 9:55 AM, CNA #3 said she answered the call light for Resident #12 that morning (09/17/2025) about 7:15 AM. CNA #3 said the resident said they needed incontinence care. CNA #3 said she told the resident that breakfast trays were about to come out, and she would tell CNA #6, the assigned CNA, that the resident needed incontinence care. CNA #3 further stated that there was a lot going on that morning (09/17/2025), and she forgot to tell CNA #6 that Resident #12 needed incontinence care. During a follow-up interview on 09/17/2025 at 10:30 AM, CNA #6 revealed she provided incontinence care to Resident #12 about 15 minutes prior at approximately 10:15 AM. CNA #6 clarified that she did not tell LPN #5 that she would be right there, but that she told the nurse to notify therapy staff that another resident was ready for therapy. CNA #6 said

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview, record review, facility document review, and facility policy review, the facility failed to secure smoking materials to ensure resident safety in accordance with the facility's smoking policy for 1 (Residents #59) of 3 residents sampled for smoking. The facility also failed to ensure an assessment was conducted to determine if a resident could safely smoke independently for 1 (Resident #72) of 3 residents sampled for smoking and failed to conduct smoking safety assessments quarterly for 1 (Resident #66) of 3 residents sampled for smoking. Findings included:A facility policy titled Smoking Policy-Residents, revised 01/2020, indicated This facility shall establish and maintain safe resident smoking practices. The Policy Interpretation and Implementation section specified the following:- 6. The resident will be evaluated on admission to determine if he or she is a smoker or non-smoker.- 7. A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff.- 11. Residents are not permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. 1. An admission Record revealed the facility admitted Resident #59 on 03/12/2025. According to the admission Record, the resident had a medical history that included diagnoses of multiple sclerosis and generalized muscle weakness. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 06/19/2025, revealed Resident #59 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. A Smoking Safety Evaluation dated 03/12/2025 indicated that Resident #59 did not utilize tobacco at the time of the resident's admission. There were no further Smoking Safety Evaluations noted in Resident #59's record. Physician Encounter notes dated from 03/17/2025 to 09/16/2025 indicated that Resident #59 was a current daily smoker. The Encounter notes indicated that smoking cessation was advised. A Progress Note dated 04/01/2025 indicated that Resident #59 was found lying in bed smoking a cigarette. The note indicated staff removed the cigarettes and lighter and educated the resident about the facility smoking policy and designated smoking area. There was no evidence to indicate the resident was found smoking in non-designated areas after this date. During an interview on 09/18/2025 at 7:20 AM, Resident #59 stated they smoked non-mentholated organic cigarettes. Resident #59 stated after dressing daily they went outside to smoke just before or after lunch and stayed outside all day. Resident #59 stated that they were not supervised while smoking and were allowed by staff to always maintain control of their smoking materials (cigarettes and lighter). Resident #59 stated they kept their cigarette and lighter in their nightstand when they were in their room and on their person when out of the room. During an interview on 09/18/2025 at 7:38 AM, Administrator (ADM) #1 stated that all smokers were able to smoke independently throughout the day except for one named resident. During an interview on 09/19/2025 at 10:10 AM, Certified Nursing Assistant (CNA) #7 stated that if a resident was an independent smoker they were allowed to smoke at any time and keep their smoking material in their possession. She stated that she was familiar with Resident #59 and was aware the resident was an independent smoker and able to maintain their own smoking materials. During an interview on 09/19/2025 at 10:14 AM, Licensed Practical Nurse (LPN) #8 stated that if a resident was assessed as an independent smoker, the resident was allowed to maintain possession of their smoking materials and was authorized to go out to the smoking patio whenever they wanted. She stated that if a resident was dependent on staff for smoking, they were monitored, and nursing would hold their smoking supplies. LPN #8 stated that Resident #59 was an independent smoker and kept their smoking supplies in their possession. During an interview on 09/18/2025 at 9:57 AM, the Physician's Assistant-Certified (PA-C) stated that Resident #59 was observed to smoke daily and this was documented in the PA-C's notes. The PA-C stated that she had counseled Resident #59 on long-term risks of smoking and had offered the resident smoking cessation program, and the resident had declined. During an interview on 09/18/2025 at 12:16 PM, the former Interim Administrator (ADM) #2 stated that he was the interim Administrator for the facility from 07/2025 until a week prior to the survey when ADM #1 started. He stated that the residents' smoking supplies were to be locked in the medication cart and residents were required to ask for them when they went to smoke. 2. An admission Record revealed the facility admitted Resident #72 on 03/05/2024. According to the admission Record, the resident had a medical history that included diagnosis of nicotine dependence. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) date of 06/07/2025, revealed Resident #72 had a BIMS score of 15, which indicated the resident was cognitively intact. Resident #72's Care Plan Report included a focus area

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, record review, and facility policy review, the facility's administration failed to require adherence to the facility's smoking policy or revise the policy to appropriately direct staff on ensuring residents' smoking safety. Interviews revealed the facility's prior administration directed staff that strict adherence to the supervision and smoking material storage aspects of the policy was no longer required; however, the policy was not revised accordingly. Additionally, administration failed to identify and address inconsistencies with adherence to the policy's requirement for quarterly smoking safety assessments. The failed practice affected 3 (Residents #59, #66, and #72) of 3 residents sampled for smoking. Findings included:A facility policy titled Smoking Policy-Residents, revised 01/2020, indicated, This facility shall establish and maintain safe resident smoking practices. The Policy Interpretation and Implementation section of the policy specified the following:- 7. A resident's ability to smoke safely will be re-evaluated quarterly, upon significant change (physical or cognitive) and as determined by the staff.- 11. Residents are not permitted to keep cigarettes, e-cigarettes, pipes, tobacco, and other smoking articles in their possession. Only disposable safety lighters are permitted. All other forms of lighters, including matches, are prohibited. 1. An admission Record revealed the facility admitted Resident #59 on 03/12/2025. A Smoking Safety Evaluation dated 03/12/2025 indicated that Resident #59 did not utilize tobacco upon admission. There was no other Smoking Safety Evaluation noted in Resident #59's medical record. During an interview on 09/18/2025 at 7:20 AM, Resident #59 stated they began smoking after admission to the facility and were now independent with smoking and required no supervision. Resident #59 stated that they kept their cigarette and lighter in a purse their nightstand when in their room and on their person when out of the room. During an interview on 09/19/2025 at 10:10 AM, Certified Nursing Assistant (CNA) #7 stated that if a resident was an independent smoker they were allowed to keep their smoking materials in their possession. During an interview on 09/19/2025 at 10:14 AM, Licensed Practical Nurse (LPN) #8 stated that if a resident was assessed as an independent smoker, they were allowed to maintain possession of their own smoking supplies and were authorized to go out to the smoking patio whenever they wanted. LPN #8 stated that Resident #59 was an independent smoker and kept their smoking supplies on them. She stated that the former administrator modified the smoking rules to allow residents to smoke at their leisure and maintain their own smoking materials. During an interview on 09/19/2025 at 5:01 PM, the Director of Nursing (DON) stated she was unaware of concerns that the facility was not completing required smoking assessments. She stated previously, all smoking materials were kept by nursing and all smoking was supervised 2. An admission Record revealed the facility admitted Resident #66 on 12/08/2022. Resident #66's Care Plan Report included a focus area initiated on 07/26/2025 that indicated the resident used tobacco. Interventions directed staff to conduct Smoking Safety Evaluation on admission and as needed. Resident #66's medical record contained Smoking Safety Evaluations dated 05/31/2024 and 08/05/2025 that indicated the resident utilized tobacco and that supervision would be utilized for all residents during designated smoking times. There was no evidence that Smoking Safety Evaluations were completed quarterly between 05/31/2024 and 08/05/2025. During an interview on 09/19/2025 at 4:44 PM, Administrator (ADM) #2 stated that the previous administration eliminated or loosened some of the restrictions and monitoring of individuals who smoked to honor the rights for those residents who were more independent with smoking. He stated the reason smoking assessments were overlooked was because of repeated changes in administration, and the current administration being unaware they were not completed. He stated he expected smoking assessments to be completed on admission, quarterly, and with all changes in the residents' condition. During an interview on 09/19/2025 at 5:01 PM, the Director of Nursing (DON) stated she was unaware of concerns that the facility was not completing required smoking assessments. The DON stated she expected smoking assessments to be completed on admission, quarterly, and as needed. 3. An admission Record revealed the facility admitted Resident #72 on 03/05/2024. Resident #72's medical record contained no evidence that a smoking safety assessment had been conducted. During an interview on 09/19/2025 at 10:14 AM, Licensed Practical Nurse (LPN) #8 stated Resident #72 was an independent smoker and kept their smoking supplies with them. During an interview on 09/19/2025 at 4:44 PM, the former Administrator (ADM) #2 stated with the repeated changes in administration, smoking assessments were overlooked, and the facility's current administration was unaware they were not completed. He stated he expected smoking assessments to be completed on admission, quarterly, and with all changes in the residents' condition. During an interview on 09/19/2025 at

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interview and facility policy review, the facility failed to ensure an effective water management program was developed and implemented to prevent the growth of opportunistic waterborne pathogens, including Legionella, which had the potential to affect all residents residing in the facility. According to the Midnight Census report, dated 09/15/2025, the facility census was 89. Findings included:A facility policy titled, Legionella Water Management Program, revised 07/2017, revealed Our facility is committed to the prevention, detection, and control of water-borne contaminates, including Legionella. The policy also revealed a section titled, Policy Interpretation and Implementation that specified, 1. As part of the infection prevention and control program, our facility has a water management program which is overseen by the water management team. 3. The purposes of the water management program are to identify areas in the water system where Legionella bacteria can grow and spread, and to reduce the risk of Legionnaire's disease. 5. The water management program includes the following elements: a. An interdisciplinary water management team; b. A detailed description and diagram of the water system in the facility, including the following: 1) receiving; 2) cold water distribution; 3) heating; 4) hot water distribution; and 5) waste; c. The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria, including: 1) Storage tanks; 2) Water heaters; 3) Filters; 4) Aerators; 5) Showerheads and hoses; 6) Misters, atomizers, air washers, and humidifiers; 7) Hot tubs; 8) Fountains; and 9) Medical devices such as CPAP machines, hydrotherapy equipment, etc. d. The identification of situations that can lead to Legionella growth, such as 1) Construction; 2) Water main breaks; 3) Changes in municipal water quality; 4) The presence of biofilm scale or sediment; 5) Water temperature fluctuations; 6) Water pressure changes; 7) Water stagnation and 8) Inadequate disinfection. G. A diagram of where control measures are applied, and j. Documentation of the program. During an interview on 09/19/2025 at 2:52 PM, the Maintenance Director stated the facility had a water management plan prior to his employment as the Maintenance Director approximately two years prior and no current testing was being performed to monitor areas for potential sources of Legionella. The Maintenance Director stated he performed checks of the water temperatures and monitored the ice machine, but he did not document that. The Maintenance Director also acknowledged he did not have a diagram or list of any areas that could be potentially at risk of being a source of waterborne bacteria and stated, This is an old building, and I don't have a clue about the plumbing. During an interview on 09/19/2025 at 4:53 PM, the Director of Nursing (DON) stated she felt that the water management plan was overseen by administration. She stated she expected the facility to develop and implement a water management plan as part of the infection control program. During an interview on 09/19/2025 at 1:57 PM, Administrator (ADM) #1 stated they no longer had a water management program after the previous administrator shut that down when the facility turned off the water fountain in the front of the building. During an interview on 09/19/2025 at 4:36 PM, the previous interim Administrator (ADM) #2 stated the facility should have an implemented water management program. He stated the facility previously had one in place until they removed all the fountains that should have extended through the entire inside and outside of the facility and included anywhere water could become stagnant in order to prevent the spread of waterborne bacteria.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility policy review, the facility failed to maintain an effective pest control program. Specifically, observations were made of pest activity on 2 of 2 units and in the conference room, kitchen, and communal bathroom. Findings included:A facility policy titled, “Pest Control,” revised 05/2008, revealed a section titled, “Policy Interpretation and Implementation” that specified, “This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.” The policy also indicated, “6. Maintenance services assist, when appropriate and necessary, in providing pest control services.” A Commercial Pest Control Service Agreement,” dated 10/10/2023 and signed by a facility representative on 11/07/2023, indicated, “This agreement is for an initial period of twelve months from the date of the first service and unless canceled by the purchaser, will automatically continue on a monthly basis until canceled by either party upon thirty day notice.” The document indicated the service frequency was monthly and included that the interior and exterior of the building would be serviced every three months, in January, April, July, and October. Additional interior services would be provided monthly. The document's “Terms and Conditions” indicated the services were conditioned upon payment in full of the initial charge and all regular service charges and that failure to pay such charges would result in cancelation of the plan. A document titled, “Greenbrier Regional Medical Center (GRMC) Maintenance Log” revealed observations of pest activity occurred as follows: - 12/13/2023: Southeast Unit room [ROOM NUMBER] - roaches observed in the bathroom. - 03/2024-04/2024: Southeast Unit room [ROOM NUMBER]W and room [ROOM NUMBER]W - ants observed. - 04/2024: Southeast Unit Rooms 105, 203, 209, and 213 - ants observed. - 06/2024: Southeast Unit room [ROOM NUMBER] - ants observed. - 07/2024: Southeast Unit room [ROOM NUMBER] - two separate entries indicated ants were observed and were observed all over the room. - 02/2025: Southeast Unit room [ROOM NUMBER] - ants observed. - 04/2025: Southeast Unit room [ROOM NUMBER] and room [ROOM NUMBER] – ants observed. - 06/2025: Southeast Unit room [ROOM NUMBER] and room [ROOM NUMBER] - ants observed. - 07/2025: Southeast Unit room [ROOM NUMBER] and room [ROOM NUMBER] - ants observed. Invoices dated from 11/2023 through 08/2025 indicated the facility received and was billed for pest control services for all months except January 2024, June 2024, September 2024, November 2024, and March 2025 through September 2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495330	A. Building B. Wing	09/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Greenbrier Regional Medical Center	1017 George Washington Highway North Chesapeake, VA 23323

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. Observations on 09/16/2025 beginning at 9:08 AM revealed one wall-mounted fly trap with an illuminated bulb in the administrative hall near the front lobby. A second wall-mounted fly trap with an illuminated bulb was noted in the hall near the courtyard. A third wall-mounted fly trap with a bulb that was not illuminated was in the hall across from the courtyard. Each door to the courtyard was observed to have an industrial air blower mounted above the doors. During a Resident Council meeting on 09/16/2025 from 11:15 AM to 11:45 AM, six (Residents #20, # 26, 55, #61, #77, and #84) of six residents who attended the meeting reported ongoing pest activity in their rooms, described as ants, flies, gnats, and spiders. During the survey, pests were observed as follows: - 09/16/2025 at 11:15 AM: a spider was observed in the public bathroom. - 09/16/2025 at 11:25 AM: flies were observed in the dining room during a Resident Council meeting. - 09/16/2025 at 2:56 PM: flies were observed in the conference room. - 09/16/2025 at 4:30 PM: gnats were observed at the 200/300/400 hall nurses' stations. - 09/17/2025 at 1:51 PM: flies were observed at the 300/400 hall nurses' stations. - 09/18/2025 at 11:05 AM: flies were observed at the 200, 300, and 400 hall nurse's station. During an interview on 09/16/2025 at 2:51 PM, Administrator (ADM) #1 stated that the facility did not have a current pest control contract because the vendor required the facility to provide a credit card to keep on file due to a history of late payments on the account. The facility did not agree to provide a credit card, so the pest control company's services ceased after February 2025. During a phone interview on 09/16/2025 at 4:28 PM, the Executive Administrative Assistant (EAA) for the facility's prior pest control service revealed that the facility signed an initial pest control contract on 10/10/2023, and the first monthly pest service was provided on 11/10/2023. The EAA stated the facility's contract was terminated after services were provided on 02/28/2025 because of non-payment. The EAA stated the facility was notified via email of the status, and the account was then paid in full. The EAA stated that she contacted the facility to renew the contract and resume the pest control services but did not receive a return call from the facility. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/17/2025 at 3:33 PM, the Maintenance Director stated he was the facility contact for the pest control provider and was responsible for addressing any pest activity reported between monthly pest services. He stated that if pest activity was reported between monthly pest services, he sprayed the facility to kill the pests with products he purchased independently through a vendor available to the public. The Maintenance Director stated he was aware there was a lapse in pest services, but he was not sure why the lapse occurred. He stated the facility was in transition with different administrators, and he thought the reason for the lapse in pest services may have been a lack of payment. He further stated that the last pest control service was provided s in February 2025 and he was aware pest control services were not provided by the vendor for the last few months. The Maintenance Director stated he was aware of two resident rooms in the facility where recurrent pest activity was identified and had been difficult to manage. The Maintenance Director also stated that he had a replacement bulb for the wall mounted fly light traps, but he had not yet been able to replace the bulb. During a follow-up interview on 09/17/2025 at 3:56 PM, ADM #1 stated that if residents observed pest activity in the facility, he expected them to notify staff, so the pest activity was addressed by the Maintenance Director with appropriate pest control products. He stated that if that did not resolve the pest problem, then a pest service provider would be contacted. The ADM stated if staff witnessed pest activity, he expected staff to report to their supervisor and have it discussed in morning meeting and resolved that day by the Maintenance Director. ADM #1 stated that he expected the Maintenance Director to resolve the pest issue and to contact the pest control vendor if he could not resolve the pest issue. The Administrator said he expected pest control services to be provided to maintain an effective pest control program. During an interview on 09/17/202 at 2:53 PM, the Director of Nursing (DON) stated she expected staff to record in the maintenance logbooks at each nursing station any pest activity observed or to report pest activity directly to the Maintenance Director. The DON stated that she expected the Maintenance Director to review the maintenance logbooks daily, address any concerns, and report on the follow-up during the morning meetings. The DON stated that if the Maintenance Director could not resolve the pest activity, then he should coordinate with management and contact the pest control vendor for the pest activity to be addressed. The DON stated that she was aware of the facility's current pest activity, described as “gnats,” from discussions during the facility's morning meetings. The DON said she expected the facility to provide and maintain a pest control program that minimized pest activity. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 09/17/2025 at 3:16 PM, the former Interim Administrator (ADM #2) stated that he was the Administrator for the facility from July 2025 until Friday, 09/12/2025, and that he was aware of residents who had voiced concerns in August 2025 regarding flies in the facility. He stated the flies were coming from the door to the smoking patio. He stated that residents propped the smoking patio door open, which allowed pests to enter the facility. He stated staff were educated to monitor the door to the smoking patio to ensure the doors were closed and not held open for extended periods of time. He stated he was not aware that the pest control contract was terminated. He stated the facility received an email from the pest control provider for the account to be paid in full, and payment was made. He said after he observed pest activity in the facility in the last month, he spoke to the Maintenance Director about pest services and was told that pest services from the vendor were on hold due to lack of payment. ADM #2 stated he contacted the corporate payable clerk and verified that the facility's bill was paid, so he expected the pest control vendor to resume services, but he did not contact the pest control vendor to verify the status of current services for the facility. 2. During a tour of the kitchen on 09/17/2025 at 11:15 AM, a fly was observed flying around in the kitchen. During an interview on 09/17/2025 at 11:15 AM, the Certified Dietary Manager (CDM) stated that there were flies in the kitchen periodically. The CDM stated the occasional observations of pests in the kitchen were no comparison to the seriousness of pests observed in the rest of the building. He stated that to minimize the flies in the kitchen, staff were to ensure the double entry doors that led to the exterior of the building near the back parking area were kept closed and staff used rolled up parchment paper to swat the flies.