STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments	{E 000}		
{F 000}	INITIAL COMMENTS	{F 000}		

An unannounced Medicare/Medicaid revisit to the standard survey of 02/06/2018 through 02/12/2018 was conducted 04/03/2018 through 04/04/2018. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. One complaint was investigated during the survey.

The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of nine current Resident (Resident #101 through Resident #108, and Resident #110) reviews and one closed Resident (Resident #10) review.

F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)	F 689	**F689** **Corrective Action(s):** Resident #109 is no longer in the facility. A Facility I&A form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents who are at high risk for falls may have potentially been affected. The facility will conduct a 100% audit of all residents to identify residents at high risk for falls and the need for safety/assistive devices and supervision. Any/all negative findings will be corrected at time of discovery. A Facility Incident & Accident Form will be completed for each resident identified at risk will also have appropriate interventions incorporated into their plan of care.

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and

§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review, clinical record review and in the course of a complaint investigation, facility staff failed to prevent one of 10 residents from two falls within 38 hours, both resulting in harm, Resident #109.

Facility staff failed to ensure Resident #109's

VDH/OLC
APR 20 2018

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tim Lawrence | TITLE: Administrator | (X6) DATE: 4/18/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1	F 689	**Systemic Change(s):** The facility policy & procedure has been reviewed and no revisions are warranted at this time. Licensed staff will be inserviced by the DON and/or Unit Manager on the policy and procedure regarding fall prevention, the use of assistive devices, adaptive equipment and supervision for preventing falls/accidents. The Risk Management Committee will review all falls weekly. All fall recommendations and interventions for fall prevention will be forwarded to the interdisciplinary team to be incorporated in the comprehensive care plan. **Monitoring:** The DON is responsible for maintaining compliance. All falls are reviewed weekly in the Risk Management Program to monitor and maintaining compliance. The DON or Unit Manager will complete the falls tracking audit weekly to monitor for appropriate safety/assistive device usage and supervision. All negative findings will be corrected at time of discovery, disciplinary action will be taken as warranted. The weekly Risk management audit results will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: April 27, 2018**

safety, resulting in two falls within 38 hours, both resulting in fractures.

Findings included:

Resident #109 was admitted to the facility on 10/13/17 with diagnoses including, but not limited to: Left knee pain with a meniscal tear, Encephalopathy, Dementia and Hypertension.

The most recent MDS (minimum data set) was a 14-day assessment with an ARD (assessment reference date) of 10/25/17. Resident #109 was assessed as moderately impaired in her cognitive status with a total cognitive score of nine out of 15.

Resident #109's EMR (electronic medical record) was reviewed on 04/03/18 at 2:05 p.m. During this review a "Fall Risk Assessment" dated 10/13/17 showed a total fall score of 15. 10 or higher on the scale equaled high risk for falls.

Section G - Functional Status on the MDS with an ARD of 10/25/17 included Resident #109 needed extensive assistance of two or more person physical assist with bed mobility and transfers; required extensive assistance of one person physical assist with locomotion on and off the unit; ambulation in her room or corridor was coded as did not occur.

The CCP (comprehensive care plan) for Resident #109 included the following: "...Problem Onset: 10/13/2017 FALL RISK Resident is at risk for falls r/t [related to] impaired cognitive status, left meniscus tear, left knee pain, weakness, and ataxic gait. Bed and w/c [wheelchair] alarms in place. Goal & Target DATE: Resident will not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 2	F 689		

experience injury from a fall requiring ED [emergency department]/hospitalization through next review. Approaches: Keep bed in lowest position with wheels locked...Keep call light within reach and encourage resident to call for assistance as needed...Ensure resident is wearing proper footwear when out of bed...Monitor for changes in health condition, ie increased confusion...Assist resident as needed with ADLs, transfers, and mobility...Ensure bed and w/c alarms are on and working properly at all times..." Both falls, 11/5/17 and 11/7/17, were listed on the CCP, but no other interventions were added to the care plan.

Nursing Progress Notes included the following documentation:

11/5/17 10:29 a.m. - "RSD [resident] found in the bed room floor with bed alarm sounding. no [sic] complaints of pain or discomfort..."

11/5/17 11:12 a.m. - "rsd [sic] sent to ED [emergency department] per RP [responsible party] request d/t [due to] left wrist pain..."

11/5/17 2:40 p.m. - "...rsd [sic] is 1-person assist with ADL [activities of daily living] transfers...Scheduled pain meds held per family. She returned to the facility from [Hospital Initials] at 1400 [2:00 p.m.]. She is s/p [status post] fall with fracture to her left second metacarpal..."

11/5/17 10:32 p.m. - "...Resident is 1-2 person for ADLs and transfers. Resident is alert to self only and is confused. Resident is also post fall. Resident fell on morning shift and has a left metacarpal fx [fracture]. Resident has complained of pain and discomfort during the shift...Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

pulled the tempory [sic] cast off of her arm..."

11/6/17 4:14 a.m. - "...Resident S/P fall and ER visit on 11/5, left arm soft splint cast intact at this time. Resident agitated at beginning [sic] of shift, ...attempted to self transfer several times, resident assisted up to w/c [wheelchair] and placed at nurses station for supervision...Safety reminders provided, however due to residents dementia unable to show understanding...Safety measures in place..."

11/6/17 2:08 p.m. - "...Resident is alert with confusion...S/P fall and ER visit with L [left] metacarple [sic] fx. Soft splint cast to LUE [left upper extremity] is C/D/I [clean/dry/intact]...Requires 1 with ADLs/transfers..."

11/7/17 4:12 a.m. - "Around 2330 [11:30 p.m.] this nurse heard resident's bed alarm sounding. This nurse went into pt's room, pt was trying in get up from bed. [sic] Attempted to redirect pt about going back to bed since it was bedtime. This nurse was not successful. CNA [certified nursing assistant] was asked to help redirect pt. Resident was gotten up in w/c and positioned at nurses' station with staff. Resident was very confused and yelling with her nurse, stating she was in a prison. Fellow nurse asked if pt was in pain and tried to assess pt, resident became more aggressive and combative. Resident did eventually calm down. At about 2430 [12:30 a.m.], this nurse was in nurses' station checking charts when this nurse noted that the pt was trying to stand up from w/c. This nurse asking pt to sit back down [sic], resident did sit was down in chair [sic]. Resident quickly then jumped up from w/c and stepped 2 steps to her left with her legs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 4	F 689		

twisted. At that time, this nurse and 2 CNA tried to get around the nurses' station to resident but was unsuccessful. Resident had fallen face first to floor infront [sic] of pantry door. Resident's alarm was sounding once was on the ground [sic]. Resident has [sic] laying on her right side and blood was coming from the top of her nose. Both CNAs was with resident while this nurse went to get the nurse for the pt."

11/7/17 7:38 a.m. - "Resident on floor from fall lying on her back. evaluated [sic] residents visible injuries. resident [sic] had abrasion on her nose that was bleeding, subsided with pressure. skin [sic] tear on lf [left] elbow bleeding applied dry dressing. abrasion [sic] to left knee and bruising appearing. resident [sic] has right arm partially under her, unable to move arm without pain...resident very vocal and confused...911 called and resident transferred to [Hospital Name] ED..."

The "Resident Incident Report" dated 11/5/17 at 10:00 a.m. including the following: "...Narrative of incident and description of injuries: RSD found in floor with bed alarm sounding...No injuries." Witness statement of Other #1 included: "Heard a cry for help. Went to room 38 found patient on floor - called for nurse and CNAs - they came and helped her." [sic] Witness statement of LPN #3 (licensed practical nurse) included: "After speaking will [sic] staff working on 11/5/17 when [Name] Resident #109 fell, her daughter had been here visiting, when she left [Name] Resident #109 tried to get OOB [out of bed] to go change her shirt because she had spilled something on it and wanted to change her shirt. Her call bell was within reach but she did not ring. Light was off when she was found. She was found @ [at] the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

bedside, said she was trying to get up to go change her shirt. Her bed alarm was sounding when nurse entered bedroom. A housekeeper alerted her that [Name] Resident #109 was @ her bedside on the floor. [Name] LPN #3 said @ first she had no complaints but shortly after started complaining of her hand hurting. Family wanted her sent to ER. She was sent and returned with a broken finger..."

This surveyor interviewed Other #1 on 4/4/18 at 9:05 a.m. regarding Resident #109's fall on 11/05/17. Other #1 stated, "She [Resident #109] had been in her w/c. I had stopped in a few minutes earlier and spoke to her and her roommate like I always do. I was in room 32 cleaning, when I heard someone holler, "Help, we need help in here." I ran to the room and she [Resident #109] was already on the floor. I ran and got the nurse. There was a low beeping (muffled), sounded like the batteries were going dead. I didn't know at the time it was an alarm. No I did not hear the beeping in the other room. I just heard someone yelling for "Help."

Documentation in the ER note dated 11/5/17 included: "...Arrived per EMS [emergency medical services] with c/o of a fall and patient with hematoma to the left hand and c/o of left arm pain from the shoulder to the hand...bruising noted to the top of the left hand...Nondisplaced fracture of base of second metacarpal bone, left hand, initial encounter for closed fracture."

The "Resident Incident Report" dated 11/7/17 at 12:30 a.m. included the following: "Narrative of incident and description of injuries: Resident in w/c with alarm at nurses station. Resident stood up nurse ask her to sit down before she and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 6	F 689		

CNAs could reach her she fell face forward to floor." [sic] Witness statement of CNA #2 included: "I came in to work at 10pm. [Name] Resident #109 was in bed awake and moving around. Her bed alarm was going off. I got her to lay back down [Name] Resident #109 laid back down. She laid there for about 30 mins. Then she was setting back up in her bed. Got her to lay back down around 11:30pm. [Name] Resident #109 would not stay in bed and the aide [Name] got her up and put her in her wheelchair with her alarm on. While [Name] Resident #109 was setting at the nurse desk. She was very confused and very combative. At around 12:30 am on Tue Nov 7 [Name] Resident #109 went to stand up and lost her balance and fell. I was running trying to get to her, but I could not get to her fast enough..."

Witness statement of LPN #2 included: "I was in another residents room giving prn [as needed] pain med. CNA called me to come to nurses station. [Name] Resident #109 was in the floor on her back 2 CNA's and nurse were present. [sic] I assessed injuries...as we were sending her to ED..."

Witness statement of CNA #3 included: "[Name] Resident #109 was in bed attempted to get up. Nurse [Name] LPN #1 asked me to assist her, so I went into the room she was trying to get her legs out of bed. [sic] I reminded her not to get up or she would fall. She wanted to get up. I then got her up put her in her wheelchair turned her alarm on and sit her in front of the nurses station the time was around 11:30 [sic] I was sitting around the nurses station on my 15 min break I was on the other side next to the med room. [sic] I heard her alarm go off I looked up and she was going

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7	F 689		

down I knew it was late to get to her as she fell her head hit the floor [Name] LPN #2 was right there as soon as it happened along with [Name] CNA #2. [sic] That was 12:30..."

Witness statement for LPN #1 included: "While in was in [sic] med room I heard [Name] Resident #109 alarm going off. She was trying to get up. I tried to tell her that it was bedtime but she continued to try to get up. I asked [Name] CNA #3 if she could get her to go back to bed. [Name] CNA #3 got her up since she said that she wanted up. [Name] Resident #109 was brought up to the desk where we all was...She was agitated. [Name] Resident #109 started screaming that we had locked her up & [and] that she was a prisoner...She went to stand up from her w/c without assistance. I asked her if she could sit back down and she did. Suddenly then she jumped up and stepped 2 steps to her left with her legs crossed. Me [LPN #1] & [Name] CNA #3 and [Name] CNA #2 got her as quick as we could but I was within the nurse station..."

This surveyor interviewed CNA #2 on 4/4/18 at 2:40 p.m. regarding Resident #109's fall on 11/7/17. CNA #2 stated, "I came on at 10:00 and got report from the off-going shift. Around 10-10:30, she was in bed. Around 11-11:30, she was trying to get up, kept sitting up making her alarm go off. [Name] CNA #3, the other girl working with me that night got her up and brought her to the nurse's desk in her w/c. She was agitated and restless. She was in her w/c sitting near the pantry door. I was sitting close to the clean utility room charting my ADL's. I had my chair positioned so I could see down the blue hall and the pink hall. I could see her from the waist up. I was able to see her because I am tall, not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

like the rest of them. I noticed she was leaning over in her w/c. I stood up to see and she stood up, took a couple of steps and fell on her face. I ran around the nurse's desk, but couldn't reach her fast enough. [Name] CNA #3 the other CNA was near the doctor's office and she ran towards her too, but couldn't reach her either. Normally we sit close to them, like in arms reach. I don't know why we weren't closer to her since she was so agitated and restless. That is a good question."

LPN #1 was interviewed via phone on 4/4/18 at 3:20 p.m. LPN #1 stated, "I was inside the nurse's station pulling charts or doing something with the charts. [Name] Resident #109 was sitting near the pantry in her w/c. I bent down to do something with a chart and when I stood up she was standing up. Before I could get out of the nurse's station and around to her, she fell. There were two aides outside of the nurse's station also. Normally someone is within arms reach. The two aides were outside the nurse's station."

LPN #2 was interviewed via phone on 4/4/18 at 3:25 p.m. LPN #2 stated, "I remember her being in the floor. I was in another resident's room giving a treatment when the aide came and got me. There was another aide and nurse with her. I knew he arm was broken because of how it was laying. We called 911. I feel they did the best they could with the 1:1. I remember she was extremely restless, like a jack in the box, up/down, up/down. She didn't want anyone touching her. She wanted her daughter and to go home. I probably would have called the daughters if she would have stayed that way, but I was giving nightly meds. She fell before I could call. I think they did the best they could."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

CNA #3 was interviewed via phone on 4/4/18 at 3:40 p.m. CNA #3 stated, "I came into work at 10:00. She was restless, kept trying to get up, so we got her up in her w/c and brought her to the nurse's station because we were afraid she was going to fall. I was on the opposite side of the desk. The nurse kept telling her to sit down. I did not see the actual fall, but I heard it. I heard the nurse say, "sit back down" and then I heard her hit the floor. My back must have been turned at the time. I guess we weren't watching her at that moment. I don't remember if the alarm was going off or not. I just remember hearing her hit the floor."

The nursing station was in the shape of a diamond, completely enclosed with a door between the North and West points of the diamond. The counters of the nurse's station were approximately four feet tall all the way around. Resident #109 was sitting in her w/c between the East and South point of the diamond. CNA #3 was near the West point of the diamond. CNA #2 was sitting between the North and West points of the diamond. LPN #1 was inside of the nurse's station with the door closed. As documented in the above interview with CNA #3, " She was restless, kept trying to get up, so we got her up in her w/c and brought her to the nurse's station because we were afraid she was going to fall." The resident was not placed near anyone that could have maybe prevented or cushioned her fall. She was brought to the nurse's station in her w/c, left to sit alone with no one in close proximity to discourage her from getting up or prevent her from falling. Per the interview with CNA #3, "My back must have been turned at the time. I guess we weren't watching her at that moment." Per the staff interview no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 689 Continued From page 10

one was watching the resident at the time of her fall.

Documentation in the ER note dated 11/7/17 included: "...presents to ED for complaint of right humerus pain and a laceration to the bridge of her nose after falling out of her wheelchair...This is her second fall in 2 days. She suffered a hand fx [fracture] on the first fall...This is the pts second fall in 36 hours. She was evaluated for the first fall and suffered metacarpal fx of the left hand. Today she suffered displaced fx of the right humeral neck and an abrasion/hematoma to the nose..."

The DON (director of nursing) was interviewed at 4:00 p.m. during a meeting with the survey team regarding Resident #109's fall on 11/7/17. The DON stated, "I don't know what they were thinking. I guess they thought they would be able to get to her in time."

No further information was received by the survey team prior to the exit conference on 4/4/18.

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident

F 689

F 695

F695
Corrective Action(s)
Resident #105's oxygen nasal cannula was discarded and replaced with a new and was dated and stored in a clear plastic bag when not in use. A facility Incident & Accident form was completed for this incident.

Identification of Deficient Practice & Corrective Action(s):
A 100% review of all residents with physician ordered oxygen was conducted to identify any/all residents at risk. Any negative findings were corrected at time of discovery and new oxygen nasal cannula was obtained and dated and stored correctly. A facility Incident &Accident form will be completed for each negative finding.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 695 Continued From page 11

interview and facility policy review, the facility staff failed to store a nasal cannula with oxygen tubing attached in a sanitary manner for one of ten residents, Resident #105.

Findings were:

Resident #105 was most recently readmitted to the facility on 12/15/2017. His diagnoses included, but were not limited to: Dementia with behavioral disturbances, Parkinson's disease, Type II Diabetes Mellitus, chronic ischemic heart disease and peripheral vascular disease.

A quarterly MDS (minimum data set) with an ARD (Assessment reference date) of 01/09/2018, determine that Resident #105 was impaired with both long and short term memory, as well as being severely impaired in daily decision making skills.

The clinical record was reviewed on 04/03/2018 at approximately 2:00 p.m. Observed on the physician order sheet was an order dated 12/28/2017 for oxygen: "O2 at 2lpm [liters per minute] via NC [nasal cannula]. May remove for meals and activities."

On 04/03/2018 at approximately 3:40 p.m., Resident #105 was observed in his room, sitting in a wheelchair. He was wearing a nasal cannula that was attached to an oxygen concentrator beside his bed. The concentrator was on and the oxygen level was set at 2 liters. Observed over the arm of his wheelchair was an additional nasal cannula that was attached to a portable oxygen tank on the back of his wheelchair. The portable tank was not on. The nasal cannula was hanging down between the arm of the wheelchair and the

F 695

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing staff will be inserviced by the DON on the proper procedure for changing, cleaning and storing of Oxygen equipment to include nasal cannulas and nebulizer tubing and masks when not in use.

Monitoring:
The DON and/or Unit Manager is responsible for maintaining compliance. The DON or Unit Manager will make weekly rounds to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: April 27, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	R-C 04/04/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 12	F 695		

resident's body. Resident #105 was asked about the nasal cannula not in use. He stated, "I don't know why that's there...I'm wearing my oxygen."

This surveyor went into the hallway and spoke with Resident #105's CNA (certified nursing assistant) #1. She was asked if she was taking care of Resident #105. She stated, "Yes." She was asked about the extra nasal cannula. She went into Resident #105's room and looked. She stated, "That's attached to his portable tank to use when he's not in his room." She was asked if the nasal cannula was usually stored between the wheelchair arm and the resident without anything over it. She stated, "No, it is suppose to be in a bag...I'll go get one now."

On 04/04/2018 a copy of the facility policy regarding oxygen administration was requested and received. According to the facility policy, "Oxygen tubing, cannula/mask should be stored in a clean, clear plastic bag when not in use."

The above information was discussed with the administrator and the DON (director of nursing) during an end of the day meeting on 04/04/2018.

No further information was obtained prior to the exit conference.

COMMONWEALTH of VIRGINIA

Department of Health

Marissa J. Levine, MD, MPH, FAAFP
State Health Commissioner

Office of Licensure and Certification

TYY 7-1-1 OR
1-800-828-1120

9960 Mayland Drive, Suite 401
Henrico, Virginia 23233-1485
FAX: (804) 527-4502

April 13, 2018

Mr. Tim Lawrence, Administrator
Heritage Hall Lexington
205 Houston Street
East Lexington, VA 24450

RE: Heritage Hall Lexington
Provider Number 495321

Dear Mr. Lawrence:

Based on deficiencies cited during the survey ending February 12, 2018, your facility was found not to be in compliance with Federal participation requirements for the long term care Medicare and/or Medicaid programs. On April 3-4, 2018, surveyors from the Virginia Department of Health's Office of Licensure and Certification conducted an unannounced revisit to verify that your facility had achieved and maintained compliance for deficiencies cited during the previous survey. One complaint was investigated during the survey. One complaint was substantiated, with deficiencies.

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Survey Results

The survey findings are reflected on the enclosed Statement of Isolated Deficiencies ("A" Form) and/or the Statement of Deficiencies and Plan of Correction (CMS-2567) and/or the Post-Certification Revisit Report (CMS-2567). All survey findings generated on these forms (including the most recent standard survey and any subsequent revisits or complaint investigations) constitute the facility's current survey report. In accordance with §483.10(g) of the Federal requirements, the current survey report must be made available for examination in a place readily accessible to residents and is disclosable to all interested parties.

We had presumed, based on your allegation of compliance, that your facility was in substantial compliance. The April 3-4, 2018 revisit established the facility continues noncompliance with program requirements, including an isolated deficiency that constitutes actual harm that is not immediate jeopardy (S/S of G), as evidenced by the attached CMS-2567L, whereby significant corrections are required.

Plan of Correction (PoC)

A PoC is not required for deficiencies cited on the Statement of Isolated Deficiencies, "A" Form. Nevertheless, the facility is expected to address and correct all areas of concern noted on this form.

Unless specifically otherwise indicated, a PoC for all certification and licensure deficiencies cited on the Statement of Deficiencies and Plan of Correction (CMS-2567) must be submitted within ten (10) calendar days of receipt of these survey findings to Pau Wade, LTC Supervisor, at: Office of Licensure and Certification, Division of Long Term Care Services, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. **If you are participating in ePOC, please submit your Plan of Correction through the ePOC website.**

To be considered acceptable, the PoC must:

1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
5. Include dates when the corrective action will be completed. (The "outside" date by which all corrections must be made is the 45th calendar day after the survey ended.)

The PoC will serve as the facility's allegation of compliance. If an acceptable plan is not submitted, the State Survey Agency may propose to the Center for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid agency that remedies be imposed immediately within applicable notice requirements.

Informal Dispute Resolution

Following the receipt and review of your survey report, please contact the assigned supervisor to attempt to resolve any problems or concerns you may have about the citations. If those concerns are not resolved, in accordance with §488.331, you have one opportunity to question cited federal certification deficiencies through the Office's Informal Dispute Resolution Process, which may be accessed at http://www.vdh.state.va.us/OLC/longtermcare/

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings. **An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.**

In regards to previously listed potential remedies, by copy of this letter we are notifying the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (DMAS) that this revisit found your facility was not in in substantial compliance with the participation requirements.

Recommended Remedies

The results of the February 12, 2018 survey were forwarded to you under the February 16, 2018 initial letter. At that time, we indicated several remedies could be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and the State Medicaid Agency (Virginia Department of Medical Assistance Services) if compliance was not achieved. We are, by copy of this letter, notifying the CMS Regional Office and Virginia DMAS that the facility had not achieved compliance with program requirements at the time of the April 3-4, 2018 revisit. Those agencies will notify you about any remedy they intend to impose.

Please be advised: The facility must maintain compliance with both the Health and the Life Safety Code requirements in order to continue provider certification.

Notification

Based on the outcome of this revisit, you must notify the facility residents, responsible parties, interested family members, staff, attending physicians, and the appropriate governing body of the current compliance status of the facility. Specifically, if a second revisit determines that the facility is still not in substantial compliance with the program requirements, it is highly probable that procedures for transferring Medicare and Medicaid recipients will be initiated. Please forward, to my attention, your plan for implementing this notification and a sample of the correspondence you will be using.

We will notify the General Assembly representatives from your District so they will also be aware of the facility's current compliance status and possible outcomes.

Survey Response Form

The Survey Response Form is offered as a method to share your review of the onsite survey process. Please take a moment to complete this evaluation, which is available at: http://www.vdh.virginia.gov/OLC/Downloadables/documents/2011/pdf/LTC%20facility%20survey%20response%20form.pdf We will appreciate your participation.

If you have any questions concerning the content of this letter, please contact me at 804/367-2100.

Sincerely,

Erik O. Bodin, Director
Office of Licensure and Certification

Enclosures

cc: Joani Latimer, State Ombudsman
Bertha Ventura, Dmas (Sent Electronically)