# Our Home, Our Family, Our Life, Too.

Heritage Hall of Big Stone Gap • 2045 Valley View Drive • Big Stone Gap, VA 24219 • (P) 276.523.3000

March 29, 2016

Center for Quality Health Services & Consumer Protection Division of Long Term Care Services 9960 Mayland Drive – Suite 401 Attn: Rodney Miller, Long Term Care Supervisor Richmond, VA 23233-1463

Mr. Miller;

Attached to this cover letter you will find Heritage Hall – Big Stone Gap's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during the annual survey process.

If I can be of further assistance don't hesitate to contact me at (276) 523-3000.

Sincerely;

Dustin Jackson Administrator

1 735

RECEIVED

APR 8 1 20%

VDH/OLC



STATEM	RS FOR MEDICARE	(X1) PROVIDER/SUPPLI		(X2) MULT	TIPLE CONSTRUCTION	FORM APPROV
AND PLA	IND PLAN OF CORRECTION IDENTIFICATION NO		MBER	A BUILDI	NG	(X3) DATE SURVEY COMPLETED
		495135	<u>.</u>	B WING		03/10/2016
	PROMIDER OR SUPPLIER	IT DAB	1		STATE ZIP CODE	
TIL TYLL	AGE HALL DIG STUN	E GAP			EW DRIVE P, VA 24219	
(X4) ID	SUMMARY ST	TEMENT OF DEFICIENCE	<u> </u>	<del></del>		
PREFIX TAG	FACH DEFICIENCY MUST OR LSC IDE	BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAS	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR( DEFICIENCY)	ILD BE COMPLETIO
F 00	INITIAL COMMENT	S		F 000		
	An unannounced Me survey was conduct. Two complaints was survey. Corrections with 42 CFR Part 48 requirements. The L survey/report will foll.  The census in this 16 177 at the time of the consisted of 24 curre (Resident #1 through record reviews (Resident #28)	ed 3/8/16 through 3, investigated during are required for cor 3 Federal Long Terrife Safety Code ow 80 certified bed facile survey. The survey Resident #24) and	/10/16. the hpliance n Care ity was y sample 4 closed			
F 278 SS=D	483.20(g) - (j) ASSES ACGURACY/COORE The assessment mus	PINATION/CERTIFII		F 278	F278 Corrective Action(s):	
	resident's status  A registered nurse muleach assessment with participation of health  A registered nurse mulassessment is comple	ist conduct or coord the appropriate professionals. ist sign and certify ti	linate		Resident #8's Admission MDS with a ARD of 3/1/16 was reviewed by the M nurse and a modification was complet to accurately code section K0300 for weight loss of 10% or more in 180 day on the MDS. A facility Incident & Accident form was completed for this incident.	MDS ced a ys
	Each individual who co assessment must sign that portion of the asse Under Medicare and M	and certify the accessment.	uracy of		Identification of Deficient Practice(s and Corrective Action(s): All other residents may have potentiall been affected. A 100% audit of all curresident assessments will be completed the MDS nurses and/or designee to ens	y ent I by
: - !	willfully and knowingly false statement in a resoubject to a civil money \$1,000 for each assess willfully and knowingly to certify a material and esident assessment is	certifies a material a sident assessment if penalty of not mor sment, or an individi- causes another indi- talse statement in	and s e than ual who vidual a		that MDS section K - weight loss is assessed and coded correctly. All negatindings will be reported to the MDS nurses for immediate correction. A Modification will be completed for each discrepancy identified on the most curr MDS.	ive h

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.

Printed: 03/23/2016 FORM APPROVED MB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1 '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495135		B WNG		03/10/2016	
	ROVIDER OR SUPPLIER SE HALL BIG STON	IE GAP	2045 V	RESS. CITY ST ALLEY VIEV ONE GAP,			
(X4) ID PREFIX TAG	EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES BE PRECEDED BY FULL INTERVING INFORMATION)	L ES	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
	This Requirement is Based on staff interit was determined the ensure a complete is Set (MDS) assessment the sample survey, The Findings including Resident #8 was a originally admitted of 2/18/16. Admitting not limited to: acute rheumatoid arthritis hypertension, demeand a urinary tract in The most current M (MDS) located in the Medicare MDS assered Reference Date (AF coded that Resident Score of 3. The fac Resident #8 require nursing care (4/3) w (ADL's). In Section Status the facility staweighed 158 pounds Loss-Loss of 5% or of 10% or more in the staff coded "No or uring the sident #8 require nursing care (4/3) w (ADL's). In Section Status the facility staweighed 158 pounds Loss-Loss of 5% or of 10% or more in the staff coded "No or uring Con March 9, 2015 a reviewed Resident #8	ent does not constitute statement.  Is not met as evidence view and clinical reconstitute and accurate Minimum and the facility staff far and accurate Minimum and for 1 of 28 Resident #8.  ed:  73 year old female worn 9/4/13 and readmidiagnoses included, kidney failure, hip from the fact of th	ced by: ord review illed to im Data dents in  ho was tted on but were acture, r accident  ment a 14 Day essment icility staff Summary that otal Living onal ent #7 Weight th or loss facility eyor Review of	F 278	Systemic Change(s): The Resident Interdiscip have been inserviced by Nurse consultant on the passessment and coding of MDS to include section It All comprehensive MDS MDS's will now be review according to the MDS so MDS nurses and/or DON accuracy and integrity of Monitoring: The DON and MDS nursesponsible for monitoring The MDS assessment and completed weekly coincided MDS calendar to monitor All negative findings from the reported to the DON at the time of discovery from the Committee monthly for reand recommendations for facility policy, procedure, Completion Date: 4/5/16	the Regional proper f all areas of the K of the MDS. I's and quarterly ewed each week hedule by the I to ensure the resident data.  The sare ag compliance. dit will be ding with the r for compliance. In the audits will and MDS nurses for immediate adings will be ssurance eview, analysis, r change in , and/or practice.	

FORM CMS-2567(02-99) Previous Versions Obsolete

9/1/15- 185.0 pounds 10/1/15- 180.0 pounds

If continuation sheet Page 2 of 12

APR 0 1 2016

VDH/OLC

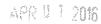
Printed: 03/23/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERV	ICES			OMR NO. 0938-0	<u> </u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495135		B. WING		03/10/2016	
NAME OF PROVIDER OR SUPPLIER	,	STREET ADD	RESS. CITY, STA	TE, ZIP CODE		
HERITAGE HALL BIG STON	IE GAP	1	LLEY VIEW			
HERITAGE TIACE DIG STOR	IL OAI	1	ONE GAP, V			
		5,00,0	OIL OAT, V		(VE)	
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCII FBE PRECEDED BY FULL I ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLE	TION
F 278 Continued From pa	age 2		F 278			
11/2/15-183.0 poun						
12/1/15-175 pound						
01/1/16-168.0 pour						
2/1/16-161.0 pound						
2/18/16-158.0 pour						
3/1/16-154.0pounds						
5/ 1/ 10 10 hopodila						
The surveyor calcul	lated that Resident#	8 had had				
	s (31 pounds) from 9					
through 3/1/16.	- (- · p · · - ) · · - · · ·					
g.						
On March 9, 2016 a	at 1:55 p.m. the surve	eyor				
	Nurse's that Residen					
	with the ARD of 3/1/					
incorrect. The surv	eyor reviewed the 14	l Day				
	one of the MDS Nur					
	ed out that Section K					
	ent #8's significant w					
loss. The surveyor	reviewed Resident#	<sup>£</sup> 8's				
weight record with N	MDS Nurse (#1). The	surveyor				
pointed out the sign	ificant weight loss wi	ithin the				
past 180 days. The	surveyor notified the	e MDS				ĺ
Nurse (#1) that the	MDS with the ARD o	f 3/1/16				1
	oded for a significan					
	80 day. The MDS N					
	ay Medicare MDS sh	nould				
have been coded as	s a weight loss.					
	t 4:20 p.m. the surve					
	strator (Adm), Direct					
	the Corporate Comp					1
	e facility staff failed t					
	urate MDS for Resid					ļ
	d the Administrative					1
	8 had a significant w					
loss over the past 18						
notified the AT that F	kesident #8's 14 Day	/ -l				1
Medicare MDs with						- 1
code/capture the sig	inificant weight loss i	n the				1

FBFI11

If continuation sheet Page 3 of 12





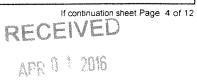
past 180 days.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/23/2016 FORM APPROVED

CENTERS F	OR MEDICARE	& MEDICAID SERV	ICES			OMB NO. 0938-0391	
STATEMENT OF C		(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495135	,	B. WING		03/10/2016	
	TIDER OR SUPPLIER HALL BIG STOP	NE GAP	2045 V	RESS. CITY. ST ALLEY VIEV ONE GAP,			
(X4) ID PREFIX (EAC TAG	CH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 278 C	ontinued From p	age 3		F 278			
ex to	iting the facility a	mation was provided as to why the facility sete and accurate MDS sident #8.	taff failed				
	3.25 PROVIDE ( GHEST WELL B	CARE/SERVICES FO EING	DR	F 309			
The Badince mediate and available and availa	povide the necess maintain the high ental, and psychologordance with the diplan of care.  Is Requirement sed on staff interview, it was deterview, it was deterview, it was detervied to follow physidents in the sale Findings Including Sident #15 was a mitted on 3/3/16. Ituded, but were intastasis, anxiety monary disease, eoarthritis.  To Resident #1 is no Minimum Diailable.  March 9, 2016 a iewed Resident in he clinical recorded 3/3/16. Physolimited to "De uth) TID X's (through Date: 3/10/16.)	a 57 year old male wheat Admitting diagnose not limited to: lung cate, congestive obstruct, depression, hyperte 5's recent admissionata Set (MDS) assess at 8:30 a.m. the surve #15's clinical record. If the produced physician is an orders included, be examethasone 2 mg pee times a day) (for)	s to attain ical, sessment seed by: ord y staff 28 nt #15. no was sincer with ive nsion and n, there sment seyor Review orders out were po (by 5 Days.		Corrective Action(s): Resident #15's attending physician notified that the facility failed to administer Dexamethasone as order the attending physician. A facility Incident and Accident form was completed for this incident.  Identification of Deficient Practices/Corrective Action(s): All other residents may have been potentially affected. The DON, AD and Unit Managers will conduct a 1 audit of all resident's physician orde MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and the comprehensive plans of care update reflect their resident specific needs, attending physicians will be notified each negative finding and a facility Incident & Accident Form will be completed for each negative finding	PON, 00% ers and heir ed to The d of	

FBFI11





Printed: 03/23/2016 FORM APPROVED DMB NO. 0938-0391

CENTER	S FOR MEDICARE	<u> &amp; MEDICAID SERVI</u>	ICES			OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIES IDENTIFICATION NUM	R/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495135		B WING		03/10/2016
NAME OF P	ROVIDER OR SUPPLIER	, , ,	STREET ADDI	RESS, CITY, ST.	ATE, ZIP CODE	
	GE HALL BIG STON	VE GAP	2045 VA	LLEY VIEW	V DRIVE	
I I kal Stiff a s	Ji. 11/11/10/10 10 10 10 1 1 1 1 1 1 1 1 1		1	ONE GAP, \		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIE T BE PRECEDED BY FULL F ENTIFYING INFORMATION)	L ES REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION DATE
F 309	the March 2016 Me Records (MAR's). MAR's documented mg was not administed the not administered at the "criteria was not Dexamethasone."  On March 8, 2016 anotified the Director Corporate Compliant facility staff did not a Dexamethasone 2 nordered by the physician record was surveyor pointed out Dexamethasone 2 nday. The surveyor MAR's with the DON and Dexamethasone did physician ordered of the Dexamethasone on March 9, 2016 amet with the Adminiting the physician ordered of the Dexamethasone on March 9, 2016 amet with the Adminiting the physician ordered of the Dexamethasone on March 9, 2016 amet with the Adminiting the physician ordered of the Dexamethasone on March 9, 2016 amet with the Adminiting the physician ordered 3/7/16 at 1 p.m. on Inotified the AT that the "criteria was not me medication. The surveyor to administer of the physician ordered of the AT that the surveyor notified the AT that the physician ordered of the physician ordered ordered ordered ordered ordered ordered ordered ordered ordered	edication Administrative Review of the March of that the Dexametha stered on 3/7/16. The hat the Dexamethason to 1 p.m. The notes stot met" to administer the at 9:45 a.m. the surver of Nursing (DON) and note Nurse (CCN) that administer the mg on 3/7/16 and 1 psician. The surveyor with the DON and CCU the specific order forms by mouth three tirthen reviewed the Mand CCN. The surveyor do the Administer of e. at 4:20 p.m. the surveyor staff held/did not adreed Dexamethasone 2 Resident #15. The staff documented	a 2016 asone 2 ae facility one was tated that the eyor nd at the o.m. as reviewed on the mes a arch 2016 reyor al or hold ey team and CCN. Team minister one mand consurveyor I that the I that no sician hasone. as to why	F 309	Systemic Change(s): Facility policy and procedures has reviewed. No revisions are warms this time. The nursing assessment as evidenced by the 24 Hour Republication of the development as the sound document for the development as monitoring of the provision of calcinctudes, obtaining, transcribing completing physician medication & treatment orders. The DON are Regional nurse consultant will in all licensed staff on the procedure obtaining, transcribing, and comphysician ordered medication and treatment orders.  Monitoring: The DON will be responsible for maintaining compliance. The DOADON and/or Unit Managers waudit/review all MAR's weekly monitor for compliance. Any/all findings and or errors will be cotime of discovery and disciplina will be taken as needed. Aggregindings of these audits will be recommendations for change in policy, procedure, and/or practice Completion Date: 4/5/16	anted at at process port and cord / urce and are, which and an orders ad/or aservice are for pleting ad  r ON, ill to I negative arrected at ary action gate reported to ee and facility
F 333	483.25(m)(2) RESID	DENTS FREE OF		F 333		

FBFI11

If continuation sheet Page 5 of 12

RECEIVED APRIL 2006



SS=D SIGNIFICANT MED ERRORS

Printed: 03/23/2016 FORM APPROVED MB NO 0938-0391

CENTERS FOR MEDICARE	: & MEDICAID SERVICES		OMB NO. 0938-039			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING	(X3) DATE SURVEY COMPLETED			
	495135	B. WING	03/10/2016			
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STATE, ZIP CODE				
HERITAGE HALL BIG STON	NF GAP 2045 V/	ALLEY VIEW DRIVE				
Eller tit treament		TONE GAP, VA 24219				
PREFIX (EACH DEFICIENCY MUST	TATEMENT OF DEFICIENCIES IT BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ULD BE COMPLETION			
F 333 Continued From pa	age 5	F 333				
	nsure that residents are free of	1 000				
any significant med	lication errors.					
· •		F333				
This Dogginsment	the state of the s	Corrective Action(s):				
·	is not met as evidenced by:	Resident #15's attending physician has				
	rview and clinical record	been notified that the facility failed to				
·	rmined that the facility staff	administer Humalog Sliding scale insulin				
	at 1 of 28 Residents in the	per physician order. The nurse involved in				
	free from Significant	the medication error has received one-on-				
medication errors, f		one inservice training from the DON on				
The Findings Includ		the administration of physician ordered				
	a 57 year old male who was	medications. A facility Incident &				
	. Admitting diagnoses	Accident form was completed for each				
	not limited to: lung cancer with	incident.				
	, congestive obstructive					
	, depression, hypertension and	Identification of Deficient Practice(s)				
osteoarthritis.	,	and Corrective Action(s):				
	5's recent admission, there	All other residents receiving diabetic				
	ata Set (MDS) assessment	medications may have potentially been				
available.	,	affected. A 100% review of all residents				
	at 8:30 a.m. the surveyor	with sliding scale insulin orders was				
	#15's clinical record. Review	conducted to identify residents at risk.				
	d produced an Insulin Sliding	All residents identified at risk will be				
	ned and dated by the physician	corrected at time of discovery and				
	ing scale protocol ordered for	appropriate disciplinary action taken. An				
	eive Humalog sliding scale.	Incident and Accident form will be				
	red for Resident #15 to	completed for each negative finding.				
	lumalog Insulin for blood	Systemic Change(s):				
sugars 261-300.	diffalog madim for blood	The facility policy and procedure has				
	the aliniant record produced	been reviewed and no changes are				
	f the clinical record produced	warranted at this time. All Licensed staff				
	dication Administrative	will be inserviced on the facility policy				
	Review of the March 2016	and procedure by the DON regarding the				
	that Resident #15's blood	administration of medications per				
•	March 4, 2016 at 7:30 a.m.	physician orders to include the proper				
	AR's also documented that the	administration of sliding scale insulin as				
	tered 10 Units of Humalog	ordered by the physician.				
	15 should have received 6	ordered by the physician.				
Units of Humalog Ins						
On March 9, 2016 at	it 9:45 a.m. the surveyor					

FBFI11

If continuation sheet Page 6 of 12

RECEIVED

APR 0 1 2016

notified the Director of Nursing (DON) and

Printed: 03/23/2016 FORM APPROVED 0MB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		i i	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135		B. WING		03/10/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BIG STON	NE GAP	2045 VA	RESS. CITY. STA LLEY VIEW DNE GAP, V	DRIVE	
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL F NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
facility staff did not sliding scale Huma a.m. The surveyor clinical record with surveyor reviewed Humalog sliding sc then reviewed the M DON and CCN. The Resident #15's blood 7:30 a.m. The survey staff administed Insulin. The survey staff should have as Humalog Insulin. On March 9, 2016 as met with the Administrate of the administrate of the facility orders for the administrate of Unit Insulin. No additional inform the facility staff faile was free from signification. The surveyor notification of a lice of the facility staff administered for the sum of the facility staff faile was free from signification. No additional inform the facility staff faile was free from signification of a lice of the purple staff of the p	administer the correction in the protocol. The surveyor pointed out that the driving of the Administered 6 Units of the Administered 6 Units of the Administered 6 Units of the Administered 10 Units of the Administered 10 Units of the Administered 6 Units of the Administered 10	et dose of at 7:30 et 7:30 et 7:30 et 5's The ordered receive yor et that 3/4/16 at et the malog et facility of ey team and CCN. Team physician estiding AT that Humalog scale eas to why eident #15 ors.	maintain designee monitor findings discover action ta results w Assuran analysis change i and/or p	inctor of Nursing is responsible for ing compliance. The DON and/of will do weekly MAR audits to for compliance. Any negative will be addressed at the time of y and appropriate disciplinary ken. Detailed findings of these will be reported to the Quality ce Committee for review, and recommendations for n facility policy, procedure,	or

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/23/2016 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERV	ICES			OMB NO	. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI	R/CLIA	1	E CONSTRUCTION	(X3) DATE SU COMPLE	
	495135		B WING		03/10	0/2016
NAME OF PROVIDER OR SUPPLIER	,		RESS. CITY STA			
HERITAGE HALL BIG STON	IE GAP		LLEY VIEW ONE GAP, V			
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	OMPLETION DATE
F 425 Continued From pa	nge 7		F 425			
(including procedur acquiring, receiving	es that assure the ac . dispensing, and drugs and biological					
The facility must en a licensed pharmac on all aspects of the services in the facility and facility document that the facility document that the facility staff ordered medications administration for 1 survey, Resident #1 The Findings Includ Resident #15 was a admitted on 3/3/16. included, but were remetastasis, anxiety, pulmonary disease, osteoarthritis. Due to Resident #15 was no Minimum Da available. On March 9, 2016 a reviewed Resident # of the clinical record dated 3/3/16. Physi were not limited to the 100mg 1 tab (tablet) (everyday) DX (diag	s not met as evidence provision of pharmaty.  Is not met as evidence view, clinical record intreview it was determined to ensure that is were available for of 28 Residents in the 5.  Ed:  57 year old male why Admitting diagnoses of limited to: lung care congestive obstruct depression, hypertermined Set (MDS) assess to 8:30 a.m. the surversion of the su	sed by: review rmined physician ne sample no was s ncer with ive nsion and n, there sment eyor Review orders but ine HCL	Resident: been noticensure the Sertraline 750mg, D Gabapent pharmacy #15. A far form has  Identificate Correctiv All reside affected. medicatio by the DO manager Residents medicatio pharmacy discovery will be no	we Action(s): #15's attending physician has fied that the facility failed to at physician ordered medications HCL 100mg, Levofloxacin examethasone 4 mg and in 300mg were available from for administration to Resident cility Incident and Accident been completed for this incident.  ation of Deficient Practices & we Action(s): contains may have potentially been A 100% review of all resident's con regimes has been conducted DN, ADON and/ or Unit to identify residents at risk. So found to be at risk due the con being unavailable from the converted at time of conducted and their attending physicians potified. A facility Incident and form has been completed for		

FBFI11

(times) 7 days discontinue date 3/10/16, Dexamethasone 4 mg po BID (twice daily)

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 03/23/2016 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495135	B. WING	03/10/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS. CITY, STATE, ZIP CODE	
HERITAGE HALL BIG STO	1	ALLEY VIEW DRIVE	
	BIG ST	ONE GAP, VA 24219	
PRÉFIX (EACH DEFICIENCY MUS	TATEMENT OF DEFICIENCIES T BE PRECEDED BY FULL REGULATORY ENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORREC PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 425 Continued From page 1	age 8	F 425	
-	p date 3/05/16 and Gabapentin		
	ve 1 cap (capsule) po BID."		
(sic)		Systemic Changes:	
	of the clinical record produced	The Pharmacy Policy and Procedure has	
	edication Administrative	been reviewed and no changes are.	
	Review of the March 2016	warranted. All licensed nursing staff have	
	that Resident #15's did not	been inserviced on the Policy and	
	ne HCL 100mg, Levofloxacin asone 4 mg and the	Procedure for medication administration	
	g on 3/4/16 at 9 a.m. The	to included medications that are unavailable or do not arrive at the facility	
	ented on the March 2016	timely from the pharmacy. The inservice	
	dications were not available	will include the steps the nurse should	
from the pharmacy.		take should a medication not be delivered	
	at 9:45 a.m. the surveyor	timely from the pharmacy.	
notified the Director	of Nursing (DON) and		
Corporate Compliar	nce Nurse (CCN) that	Monitoring:	
	ot receive physician ordered	The DON is responsible for maintaining	
	16. The surveyor reviewed	compliance. The DON and/or designee will conduct medication reviews of	
	ith the DON and CCN. The	resident medication orders each week	
	Resident #15's physician	coinciding with the Care plan calendar to	
	Nand CCN. The surveyor  March 2016 MAR's with the	check for the availability of all ordered	
	e surveyor pointed out that	drugs. All negative findings will be	
	umented that the physician	corrected at the time of discovery.	
	s were not available from the	Results of the reviews will be reported to	
	veyor asked the DON and	the Quality Assurance Committee for	
	ad a backup pharmacy and	review, analysis, and recommendations for change in facility policy, procedure,	
the DON named a lo	ocal pharmacy. The surveyor	and/or practice.	
requested a copy of	the facility policy and	Completion Date: 4/5/16	
procedure for obtain			
	t 4:20 p.m. the survey team		
	strator (Adm), DON and CCN.		
	d the Administrative Team		
	staff failed to ensure that		
pnysician ordered madministration for Re	edications were available for		
	at 7:30 a.m. the surveyor		
	policy and procedure titled,		
	tat/Emergency Deliveries,"		

RECEIVED 9 of 12

VDH/OLC

FBFI11

that had been left on the table in the conference

Printed: 03/23/2016 FORM APPROVED OMB NO. 0938-0391

						<u> </u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		1	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	495135		B WING		03/	10/2016	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BIG STON	IE GAP	2045 V	RESS. CITY. ST ALLEY VIEV ONE GAP, V	V DRIVE			
PREFIX (EACH DEFICIENCY MUST	ATEMENT OF DEFICIENC! I BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
"Procedure 1. The notify the Pharmacy from a prescriber a require an interim/s necessary medicate Facility's interim/state determined that an delivery is indicated Arrange with the Pharmacy of the medical process of the medical p	and procedure read in Facility should immery when the Facility remedication order that tat/emergency delivered on is not contained wit/emergency supply, interim/stat/emergent, the Facility should harmacy to include the fine of the facility should harmacy to include the facility should harmacy to include the facility should harmacy to include the fine of the facility should harmacy to include the fine of the facility should harmacy to include the fine of the facility should harmacy to include the facility should have a special delivery, by contract courier, dication to be dispensive the facility of the facility should be dispensive that physical should be sho	diately ecceives at may erry. 2. If a within the and it is not either: 2.1 ne an earlier or or 2.2 sed and	F 425				
F 513 483.75(k)(2)(iv) X-F SS=D IN RECORD-SIGN/	AY/DIAGNOSTIC R DATED	EPORT	F 513				
record signed and of other diagnostic ser.  This Requirement is Based on staff interpretering it was determ failed to ensure that results were in the concept of Residents in the sar. The Findings Included Resident #3 was an admitted on 2/1/16, included, but were not the sar.	s not met as evidence view and clinical reconined that the facility physician ordered X slinical record for 1 of apple survey, Residered: 82 year old female voluments Admitting diagnoses of limited to: thoracids, pressure ulcer on ression, obesity, atria	eed by: ord staff f-rays f 28 nt #3. who was c 11 and sacrum, al	Resident # been notifi physician of thoraclumb in the resident &	e Action(s): 3's attending physician has led that the results of a ordered X-ray for a bar X-ray were not available dent medical record. A Facility Accident form has been for missing diagnostic test		,	

FORM CMS-2567(02-99) Previous Versions Obsolete

FBFI11

If continuation sheet Page 10 of 12

APR 0 1 2015

RECEIVED

VDH/OLC

Printed: 03/23/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING\_ COMPLETED 495135 B WING 03/10/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERITAGE HALL BIG STONE GAP 2045 VALLEY VIEW DRIVE **BIG STONE GAP, VA 24219** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 513 Continued From page 10 F 513 femur fracture. Identification of Deficient Practices & The most current Minimum Data Set (MDS) Corrective Action(s): located in the clinical record was a 30 Day All other residents with physician ordered Medicare MDS with an Assessment Reference X-rays or diagnostic test may have Day (ARD) of 2/29/16. The facility staff coded potentially been affected. A 100% review that Resident #3 had a Cognitive Summary Score of all resident medical records will be of 14. The facility also coded that Resident #3 conducted by the Unit Mangers, Medical required extensive assistance (3/3) with Activities Records and/or designee to identify of Daily Living (ADL's). residents at risk. A Risk Management On March 8, 2016 at 1:30 p.m. the surveyor Incident & Accident Report will be made the initial tour of the facility with a completed for each negative finding. Registered Nurse (RN). The RN informed the surveyor that Resident #3 had fractures in her Systemic Change(s): back and that the facility had recently

discontinued the back brace that Resident #3 had been required to wear. On March 9, 2016 at 8:45 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record a Physician Telephone order dated 3/2/16. The physician telephone order read in part ... "Canceled X-ray of thoracolumbar spine @ (at) (name of vendor withheld) 10 am on

3/5/16 s/t closed. ? (change) to 3/4/16 @ 10am."

Additional review of the clinical record failed to produce the results of the physician ordered X -Ray of the thoracolumbar spine on 3/4/16. On March 9, 2016 at 9:05 a.m. the surveyor notified a Licensed Practical Nurse (LPN #5) that Resident #3 had a physician order to obtain an X-Ray of the thoracolumbar spine on 3/4/16. The surveyor notified LPN (#5) that the results of the physician ordered X-Ray was not in the clinical record. The surveyor reviewed the clinical record with LPN (#5). The surveyor pointed out the specific physician order for the X-Ray of the thoracolumbar spine. LPN (#5) reviewed the clinical record and was unable to locate the results of the physician ordered X-Ray. LPN (#5) stated that Resident #3 had gone out of the

The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include timely and accurate filing of laboratory test results, X-ray and Diagnostic test results according to the acceptable professional standards and practices.

#### Monitoring:

The DON is responsible for maintaining compliance. The DON, and/or designee will complete lab/diagnostic test audits weekly to monitor for complaince. Any/all negative findings will be corrected at time of discovery. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 4/5/16

FORM CMS-2567(02-99) Previous Versions Obsolete

If continuation sheet Page 11 of 12

RECEIVED

APP 0 1 2016

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES.

Printed: 03/23/2016

CENT	RS FOR MEDICARE	& MEDICAID SERVICES				MAPPROVEI D. 0938-039
	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S COMPLI	URVEY		
		495135	B. WING		03/1	0/2016
}	PROVIDER OR SUPPLIER AGE HALL BIG STON	IE GAP 20	ET ADDRESS, CITY, ST 045 VALLEY VIEW IG STONE GAP,	V DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIES FBE PRECEDED BY FULL REGULA INTIFYING INFORMATION)	ID TORY PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 51	notified LPN (#5) th contained in the clin she would attempt to physician ordered X On March 9, 2016 at Compliance Nurse (results of the physician spine X-ray. The find a moderate compress demonstrated. The approximately 50% are wall remains into the hypoplastic. There is degenerative disc distense is mild disc distense is mild disc distense is mild disc distense with the Administrative Techad a physician order spine X-Ray on 3/4/1 AT that the results of was not contained in No additional informathe facility staff failed	Ray done. The surveyor at the results should be nical record. LPN (#5) state of find the results of the (-Ray. at 9:45 a.m. the Corporate (CCN) hand delivered the sian ordered thoracolumbar idings read in part "Ther ission deformity of T12 aga vertebral body has lost of its height. The posterior act. The T12 ribs are is mild-to-moderate sease at L3-4 and L4-5 and ease at L2-3." (sic) at 4:20 p.m. the survey team strator (Adm), Director of CCN. The surveyor notified the company of the surveyor notified the company of the physician ordered X-F	e is in  d  f  f  eay			

FORM CMS-2567(02-99) Previous Versions Obsolete

FBFI11

If continuation sheet Page 12 of 12

