Our Home, Our Family, Our Life, Too.

January 27, 2016

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

Ms. Cacciatore,

Attached to this cover letter you will find Heritage Hall – Clintwood'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 our annual survey.

If I can of further assistance don't hesitate to contact me at (276) 926-4693.

Sincerely,

Glenna W. Kennedy, Administrator

Heritage Hall - Clintwood

P.O. Box 909

Clintwood, VA 24228

RECEIVED

FEB 0 1 2016

VDH/OLC



State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 495320 01/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERITAGE HALL CLINTWOOD 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 000 Initial Comments F 000 An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 01/11/16 through 01/13/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life RECEIVED Safety Code survey/report will follow. The census in this 100 certified bed facility was 79 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 13) and 3 closed record reviews (Residents 14 through 16). F 001 | Non Compliance F001 F 001 Resident Rights 12VAC 5-371-240 (C. 10) Cross The facility was out of compliance with the reference to F-155 following state licensure requirements: Cross Reference to POC for F Tag- 155 This RULE: is not met as evidenced by: The facility was not in compliance with the Resident Behavior and Facility Practice following Virginia Rules and Regulations for the 12 VAC 5-371-330 (A-I) Cross Licensure of Nursing Facilities: reference to F-221 Resident Rights Cross Reference to POC for F-221 12 VAC 5-371-240 (C.10)-Cross reference to F155 Resident Assessment Resident Behavior and Facility Practices 12 VAC 5-371-250 (A, D, E) Cross 12 VAC 5-371-330 (A-I)-Cross reference to F221 reference to F-278 Resident Assessment 12 VA 5-371-250 (A, D, E)-Cross reference to Cross Reference to POC for F-278 **Dietary Services Dietary Services** 12 VAC 5-371-(Restaurant 12 VAC 5-371-(restaurant regulations)-Cross Regulations) Cross reference F-372 reference to F372 Administration Cross Reference to POC for F Tag-F-372 12 VAC 5-371-310 (A) - Cross reference to F502 12 VAC 5-371-360 (E.4, 9)-Cross reference to TITLE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

STATE FORM

If continuation sheet 1 of 2

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State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495320 B. WING_ 01/13/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE HERITAGE HALL CLINTWOOD 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 001 Continued From Page 1 F 001 Administration 12 VAC 5-371-310 (A) Cross reference F514 F-502 12 VAC 5-371-360 (E.4, 9)Cross reference F-514 Cross Reference to POC for F Tag-502 and F-Tag-514 Completion Date: February 26, 2016 RECEIVED VDH/OLG

PRINTED: 01/21/2016 FORM APPROVED OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER		1	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	1 01/10/2010
-				5 CLINTWOOD MAIN STREET, ROUTE	507 DO DOV 000
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F 000 INITIAL COMMEN	тѕ	FC	00		
survey was conducted Corrections are reducted CFR Part 483 Feder requirements. The survey/report will for	ollow.				
79 at the time of th consisted of 13 cur (Residents 1 through reviews (Residents 5 483.10(b)(4) RIGH SS=D ADVANCE DIRECTOR The resident has the refuse to participate and to formulate and specified in paragra	TTO REFUSE, FORMULATE TIVES The right to refuse treatment, to be in experimental research, an advance directive as apply (8) of this section.	; F1	55	F155 Corrective Action(s): Resident #12 has had their DDNF and physician orders reviewed by attending physician and they have updated and correctly completed resident #12's DNR status. An Incand Accident form was completed incident.	the been to reflect cident
specified in subpart related to maintain procedures regarding requirements include provide written inforconcerning the right or surgical treatment option, formulate and includes a written described in the subpart of	amply with the requirements to 1 of part 489 of this chapter and my advance directives. These de provisions to inform and remation to all adult residents to accept or refuse medical and, at the individual's an advance directive. This escription of the facility's and advance directives and w.			Identification of Deficient Pract Corrective Action(s): All other residents may have been potentially affected. The Admissi Director will review all resident's records and contact all responsible for a resuscitation status and advardirectives to insure that the proper has been explained and that written notification has been placed in the medical record.	on medical parties nce status n
	;				RECEIVED FEB U1 2016
ADODATONY DIDECTORS OF THE	EDIGUEDUED DEDETATIVE AND	LATILET		TITLE	DHIQLE
///	BERJSUPPLIER REPRESENTATIVE'S SIGN	AI URE	ÜÜ	ministratur	1-27-2014

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

Facility ID: VA0109

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		495320	B. WING	}		01/13/2016
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HERITA	GE HALL CLINTWOOL) :		1	225 CLINTWOOD MAIN STREET, ROUTE 6 CLINTWOOD, VA 24228	07 PO BOX 909
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	by: Based on staff intereview, the facility status and the DDN Resuscitate) order of for 1 of 16 residents. The findings include The facility staff failed code status was accomplete. The surveyor review record on 1/13/16. It has facility 10/28/15 diagnoses that inclustage renal failure worth urgathy with stent, tract infection, proteinsufficiency with righypercalcemia with an emia. Resident #12's 5 datassessment with an (ARD) of 11/4/15 astassessment with an (ARD) of 11/4/15 astassessment of Healt Resuscitate (DDNR) DDNR form included in part: "I further certify (muant of the patient is conformed decision 2. The patient is informed decision	rview and clinical record taff failed to ensure the code R (Durable Do Not were complete and accurate (Resident #12). Ed to ensure Resident #12's curate. Resident #12's DDNR suscitate) form was red Resident #12's clinical Resident #12 was admitted to and readmitted 12/31/15 with ded but not limited to end ith dialysis, obstructive major depression, urinary in-calorie malnutrition, venous ht lower leg ulcer, parathyroid tumor, and y minimum data set (MDS) assessment reference date sessed the cognitive status action C Summary Score. Contained a Virginia h Durable Do Not order dated 1/4/16. The lin the clinical record stated	F	155	Systemic Change(s); Facility policy and procedure was reviewed and no changes are warrant this time. The Admissions Director heen inserviced on the proper comple of a DDNR and Advance Directives required. The Admission Director will discuss with each future Admission that advance directors and resuscitation strupon admission to the facility. Any/a concerns expressed will be reported to Administrator. The Administrator & Director of Nursing will speak to the concerned or with questions about earea & follow through on all concernensure proper resuscitation status is reflected in the medical record. Monitoring: The Admission Director is responsibly maintaining compliance. The Admission Director will audit all Residents med records monthly to monitor compliant for having a current resuscitation ord and/or advance directive Any/all neg findings will be reported to the Administrator for immediate correctinaction to include an investigation. Completion Date: February 26, 20	as etion when III heir ratus III o the see ch s to



Event ID: S9YQ11

Facility ID: VA0109

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decision, the advanced of B. While decision, the advanced of Authorized C. The produced of There were DDNR form DDNR form and the resident #1 However, the signed 1/4/1 The surveyor and the region 9:10 a.m. The surveyor director of nocoordinator, the above find No further in exit conference of PHYSICAL The resident physical residesipline or	e capable e patien directive. e capable e patien lirective to Constitute	e of making an informed thas executed a written e of making an informed thas executed a written which appoints a "Person ent on the Patient's Behalf " as not executed a written" eks in any of the boxes on the ection at the bottom of the en signed by the physician he form was dated 1/4/16. bital discharge orders dated exember 2015 admission the facility identified NR-Do Not Resuscitate". rry 2016 physician order sheet if yell Code." ewed the director of nursing istered nurse on 1/13/16 at the discrepancy. ed the administrator, the he minimum data set (MDS) regional registered nurse of 1/13/16 at 10:45 a.m. on was provided prior to the /13/16. DBE FREE FROM	F 2	Resid nursir physic buddy care p chang buddy party and be the ch	ective Action(s): ent #10 has been reassessed ig, therapy, and the attendir cian for the need and use of while in the chair. Resider elan has been revised to refl ges made to include using a while in chair. The respon was notified and explained enefits of using a lap buddy air and consent was obtain ty Incident & Accident for leted for this incident.	ng f a lap nt #10's lect lap sible the risks while in ed. A

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Event ID: S9YQ11

Facility ID: VA0109

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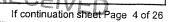
DEPARTMENT OF HEALTH AND HUMAN SERVICES

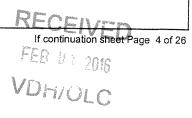
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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495320 NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 221 Continued From page 3 F 221 Corrective Action(s): All other residents utilizing restraints may have been potentially affected. The facility conducted a 100% review of all	PROVEI
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 221 Continued From page 3 F 221 Identification of Deficient Practice(s) & Corrective Action(s): All other residents utilizing restraints may have been potentially affected. The	JRVEY
This REQUIREMENT is not met as evidenced STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 90 CLINTWOOD, VA 24228 ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 221 Continued From page 3 F 221 Identification of Deficient Practice(s) & Corrective Action(s): All other residents utilizing restraints may have been potentially affected. The	2046
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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 221 Continued From page 3 F 221 Continued From page 3 F 221 Identification of Deficient Practice(s) & Corrective Action(s): All other residents utilizing restraints may have been potentially affected. The	09
Corrective Action(s): All other residents utilizing restraints may have been potentially affected. The	(X5) MPLETION DATE
Based on observation, staff interview, facility document review and clinical record review the facility staff failed to ensure that 1 of 16 Residents was free from unnecessary physical restraints, Resident #10. The findings included: For Resident #10, the facility staff failed to assess and monitor for the use of physical restraints. Resident #10 was admitted to the facility on 11/06/15. Diagnoses included but not limited to atrial fibrillation, hypertension, gastroesophageal reflux disorder, urinary tract infection, hyperlipidemia, anxiety, chronic obstructive pulmonary disease and altered mental status. The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 11/13/15 coded the Resident #10 as total dependence, two person physical assist in all areas of transfer and mobility. Section P, restraints, coded Resident #10 as not using any type of physical restraint. Section V, care area assessment, did not indicate physical restraint for care planning. Resident #10. Was admitted to assess and monitor for the use of physical assist in all areas of transfer and mobility. Section P, restraints, coded Resident #10 as not using any type of physical restraint. Section V, care area assessment, did not indicate physical restraint for care planning. Resident #10 was admitted to assess and monitor for the facility of the restraint and that consent the use of transfer and mobility. Section P, restraints, coded Resident #10 as not using any type of physical restraint. Section V, care area assessment, did not indicate physical restraint for care planning. Resident #10 was noted to wassess and monitor for the facility of the restraint and that consent the use of the restraint and that consent the	

#1 on 01/11/16 at approximately 3:30 PM

regarding Resident #10. CNA #1 stated to



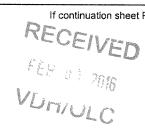


DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	buddy if she wanted what was the purpo #1 stated, "to keep chair when she lear Surveyor spoke with nurse) #1 on 01/11/regarding Resident #10 could remove Is Surveyor checked thank the Velcro was difficult to pull loose #10 to remove the Is surveyor and raised but did not remove in Resident #10's clinic 01/12/16. The physician's order for could not locate any indicating a need for that any type of more while lap buddy was restraint. Resident #10's CCP was reviewed and it regarding the use of Surveyor spoke with 01/12/16 at 11:15 Af of lap buddy. The Do surveyor to observe Resident #10 was of at nurses' station. Le wheelchair and hang DON stated that the safety measure to proward from chair.	ent #10 could remove lap It to. Surveyor asked CNA #1 Is e of the lap buddy, and CNA Is her from falling out of her Is too far over". In LPN (licensed practical It to a tapproximately 3:45PM It to LPN #1 stated Resident Is to buddy by herself. In the straps on the lap buddy Is firmly attached to itself and Is Surveyor asked Resident Is buddy. Resident smiled at It the lap buddy up and down, It to a trecord was reviewed on It cal record was reviewed on It to a treveror could not locate a Is use of lap buddy. Surveyor It type of assessment Is puddy, any indication It to into the lap buddy In the lap buddy and indication It to into the lap buddy Is the lap buddy and indication It to into the lap buddy Is the lap buddy and indication It to into the lap buddy Is the lap buddy and indication It to into the lap buddy Is the lap buddy and indication It to into the lap buddy Is the lap buddy and indication It to into the lap buddy Is the lap buddy and indication It to into the lap buddy Is the lap buddy and indication Is the lap buddy and indicati	F 2	221:	Monitoring: The DON is responsible for compl Residents utilizing restraints will b reviewed weekly in risk manageme monitor compliance. The audit find the Risk Management meeting will reported to the Quality Assurance Committee for review, analysis, an recommendations for change in factoric policy, procedure, and/or practice. Completion Date: February 26, 2	eent to dings at be d	

entitled "Restraint Utilization and Reduction"



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F 221		ge 5	F 2	21		
	which read in part:					
	"POLICY: Restrair	nt Utilization and Reduction pany name omitted) is to				
	provide a restraint f	ree environment for all				
	ResidentsWher	safety devices are necessary				
		each his or her maximum				
		ndependence, we will monitor a continuous basis.				
		ety device is indicated a				
	physician's order m	ust follow.				
		traint is defined as any				
		device attached or adjacent to				
		innot be easily removed by the is freedom of movement or				
	normal access to or					
	PROCEDURE:	· · · · · · · · · · · · · · · · · · ·				
		estraint Need Assessment				
	team upon admission	ation of the interdisciplinary				
		nd/or responsible party will be				
	informed of the risks	s and benefits for restraint use				- warning
	as outlined on the S	afety Device Consent Form.				
	3					
	 Prior to implement that consent 	entation the team must				
		e party and documented				
	accordingly.	o party and addamented				
	5					
		ng of the Resident's needs,				
		ng through 30-minute checks				
	(10) minutes	our releases for at least ten				
	 Documentation i 	is essential.				
	8					
		ety devices will be reviewed				
		or possible elimination and/or				
	reduction in use. DOCUMENTATION					
						1

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Any Resident utilizing a restraint will have the

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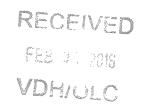
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	PROVIDER OR SUPPLIER GE HALL CLINTWOOL) <u>,</u>		122	EET ADDRESS, CITY, STATE, ZIP CODE 5 CLINTWOOD MAIN STREET, ROUTE NTWOOD, VA 24228			
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F 278 SS=B	1. Type of restraint. 2. Medical diagnosis use. 3. Specific check/re minute checks and minutes with superv Any Resident utilizin following documents (activities of daily liv 1. Type of restraint 2. Restraint check The use of the lap b order, consent, assed discussed with the a 01/12/16 at approxin No further information 483.20(g) - (j) ASSE ACCURACY/COOR The assessment muresident's status. A registered nurse meach assessment wiparticipation of healt A registered nurse massessment is comp Each individual who assessment must signature and willfully and knowingles.	ation on the physician's order: s/symptom requiring restraint lease time frames of 30 1 hour releases for 10 ision. Ig a restraint will have the ation on the Resident's ADL ing) sheet: ted, released and reapplied." uddy without a physician's essment or monitoring was administrative team on mately 1450. In provided prior to exit. SSMENT DINATION/CERTIFIED Ist accurately reflect the ust conduct or coordinate th the appropriate h professionals. ust sign and certify that the leted. completes a portion of the gn and certify the accuracy of	F 2		F278 Corrective Action(s): Resident #3's Quarterly MDS asses with an ARD of 11/27/2015 was revely the RCC and a modification was completed to accurately code and complete section O of the quarterly to reflect the correct Restorative Nuthat was performed. Resident #3's Significant Change Assessment wit ARD date of 9/22/15 was reviewed Modification was completed to accurate to accurate the complete to accurate the complete to accurate the complete that the complete the correct Restorative Nuthat was performed. Resident #3's Significant Change Assessment with ARD date of 9/22/15 was reviewed Modification was completed to accurate the complete that the com	MDS rsing h an and a urately nange		

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 278	\$1,000 for each ass willfully and knowing to certify a material resident assessmer penalty of not more assessment.	ney penalty of not more than essment; or an individual who gly causes another individual and false statement in a at is subject to a civil money than \$5,000 for each	F 2	278	ARD date of 10/23/15 was reviewed a Modification was completed to accurately code sections O for restora Nursing and section V of the Annual Assessment. A facility Incident & Accident form was completed for this incident.	and tive	
:	This REQUIREMEN by: Based on staff inter review, the facility st accurate MDS (mini for 10 of 16 resident	IT is not met as evidenced view and clinical record aff failed to ensure an mum data set) assessment s (Resident #5,	•		Resident #1, #2, #4, #5, #6, #8, #9 & # have had their most recent Comprehensive MDS assessment reviewed by the RCC and a modificati was completed for each one to accurat code and complete section V of their recent Comprehensive MDS Assessment A facility Incident & Accident form we completed for this incident.	ion ely nost ent. as	
	#8, Resident #1, Re Resident #10). The findings include 1. The facility staff frestorative nursing a complete Section V (Care Area Assessm completed. Resident #3's clinica 1/11/16 and 1/12/16 to the facility 8/1/14 a diagnoses that include wasting and atrophy. Diabetes Mellitus, shunstageable pressur ischemic attacks, mohyperkalemia, dysph	ailed to accurately code and failed to accurately for Resident #3. The CAA ents) worksheets were not I record was reviewed Resident #3 was admitted and readmitted 11/18/15 with ded but not limited to muscle muscle weakness, Type 2			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 RCC and/or designee to ensure that MDS sections V and section O—restorative nursing are assessed and cocorrectly. All negative findings will be reported to the RCC for immediate correction. A Modification will be completed for each discrepancy identificant the most current MDS.	y eent I by	

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(a). The facility staff failed to accurately code

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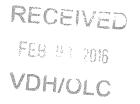
OLIVIL	NO FOR MEDICARE	& MEDICHID SEKVICES	-			NNR NC). 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION		TE SURVEY MPLETED
		495320	B. WING			01	/13/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	***	
LICOTTA	CE HALL CLINEWOOD			12	225 CLINTWOOD MAIN STREET, ROUTE	607 PO E	OX 909
HERITA	GE HALL CLINTWOOD	,			LINTWOOD, VA 24228		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	381	74.4 m
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
	data set (MDS) assereference date (ARI was assessed with a 15 out of 15 in Section O Special T Programs was also coded for range of range of motion (act training (7 days) and days). A review of the restorative care flow period (11/21/15 through Resident #3 receive active range of motion transfers from bed/of for 7 days, active rand left upper and loduring the look back nu-step (omnicycle) unable to locate whe passive range of motion. The surveyor intervien ursing assistant (R. 9:30 a.m. The reston November 2015 rest stated Resident #3 comotion in November was done was active licensed practical nup.m. She stated she record herself instead	rative nursing. yed the quarterly minimum ressment with an assessment D) of 11/27/15. Resident #3 a cognitive summary score of on C Summary Score. reatments, Procedures, and reviewed. Resident #3 was notion (passive) for 7 days, rive) for 7 days, transfer d eating/swallowing training (7 he November 2015 record for the look back ough 11/27/15) revealed red restorative nursing for on (feed self) for 7 days, rhair for 7 days, combing hair nge of motion to both right ower extremities every day period for 7 days, and 7 days. The surveyor was re Resident #3 received tion during the look back rewed the restorative certified a.C.N.A.) #1 on 1/12/16 at retive C.N.A. #1 reviewed the orative flow record and lidn't need passive range of a. She stated everything that b. The surveyor interviewed rese #3 on 1/12/16 at 1:05 a should have checked the	F 2	· · · · · · · · · · · · · · · · · · ·		f the the the d ed	
,	(b) The surveyor revi in assessment minin assessment with an	ewed the significant change					

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Event ID: S9YQ11

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		& MEDICAID SERVICES	~~		O	MB NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495320	B. WING			01/13/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE	**************************************
HERITA	GE HALL CLINTWOOL	2		1225 CLINTWOOD MAIN STRE	EET, ROUTE 6	07 PO BOX 909
IIIIXIIA	OF HALE OF HALAMOOF	,		CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEN	CTION SHOULD O THE APPROPE	BE COMPLETION
F 278	Continued From pa	ge 9	F 2	78		
		nmary score of 15 out of 15 in		. •		
	Section C Summan	Score. Section V [CAAs				
		ment) and Care Planning] was				
		information written in the last				
	column read "Curre	nt Care Plan Continued."				
		nation documented where the				
	date and location re	lated to the CAA information				
		e CAA worksheets did not				
		on complicating factors, risks,				
	or any referrals for t	he areas that were triggered				
	as care planned [co	gnitive, communication, ADL				
	(activities of daily liv	ing), urinary, behaviors, falls,				
	nutrition, dehydratio	n, and pressure ulcers].	•	•		
	The surveyor intervi	ewed the minimum data set				
	(MDS) coordinator of	on 1/12/16 at 2:00 p.m. She				1
		and stated she did have tools				.
		ered items but stated these				`
		art of the clinical record. She				
		ts were not accurate.				
	The surveyor inform	ed the administrator, director				
	of nursing, the minin	num data set (MDS)				
		regional registered nurse of				
		1/12/16 at 3:00 p.m.		•		
		on was provided prior to the				
	exit conference on 1					
		ailed to ensure Section V of				
		et (MDS) assessment was				
	accurate. The date					
		found to support the				
		e care plan was not				
	completed for Reside					
		Resident #5 was reviewed				
		Resident #5 was admitted				
		3 with diagnoses that				
		ed to pain, unspecified				
		ed intellectual disabilities,				
	gastroesophageal re	nux uisease without				
	esophagitis, and hype					
	resident #5's annual	minimum data set (MDS)				

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE	
		495320	B. WING			04/4	12/2040
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 01/1	3/2016
HERITA	GE HALL CLINTWOOI				5 CLINTWOOD MAIN STREET, ROUTE NTWOOD, VA 24228	E 607 PO BOX	X 909
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	(ARD) of 11/13/15 a cognitive summary C Summary Score. Triggered areas ma ADL (activities of da nutrition, pressure use. The location a read "Current Care The area did not incompare the information to suconcerns. The CAP documentation when triggered areas. The surveyor intervial (MDS) coordinator or reviewed Section V for each of the triggered area were tools and not postated the workshee The surveyor inform of nursing, the mining coordinator and the the above finding on No further information exit conference on 13. The facility staff for restorative nursing a V accurately for Res The clinical record of 1/11/16 and 1/12/16. The to the facility 10/7/08 diagnoses that including the pastroesophageal restores.	assessment reference date assessed the resident with a score of 6 out of 15 in Section Section V was reviewed. rked were: cognitive loss, ally living), urinary, falls, alcers, and psychotropic drug and date of CAA information Plan Continued 11/14/15." lude the date or location of apport the triggered care plan worksheets had no re to locate information for the ewed the minimum data set an 1/12/16 at 2:00 p.m. She and stated she did have tools ered items but stated these art of the clinical record. She ts were not accurate. ed the administrator, director and data set (MDS) regional registered nurse of 1/12/16 at 3:00 p.m. In was provided prior to the resident #7. Fresident #7 was reviewed Resident #7 was admitted and readmitted 6/6/12 with ded but not limited to anial hemorrhage, pain, type urine retention, insomnia,	F 2	78:			

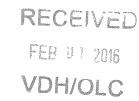
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atrophy, muscle weakness, age related osteoporosis, chronic kidney disease, kidney

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OLIVIL	INO I ON MEDICANE	A MEDICAID SERVICES			OMB NO	<u>0. 0938-0391</u>
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DA	ATE SURVEY DMPLETED
		495320	B. WING		0-	1/13/2016
	PROVIDER OR SUPPLIER GE HALL CLINTWOOL)		STREET ADDRESS, CITY, STATE, ZIP 1225 CLINTWOOD MAIN STREET, CLINTWOOD, VA 24228	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	stone, dysphagia, c lack of coordination Resident #7's annual assessment with an (ARD) of 10/23/15 a cognitive summary: O Special Treatment coded 7 days of acts Resident #7. The standard period 10/17/1 Documentation on the Resident #7 receive "Nu-step" on 10/18/7 Resident #7 receive three (3) days during as coded on the MD The surveyor intervienursing assistant #1 stated "Resident #7 wants. If we don't do be charted as a refused ocumentation for 10 or 10/23/15. The surveyor interviewal the aide had told her (b). The facility staff the was complete and act A review of Section V Assessment) and Caleach triggered item, in the last column reaction there we continued." There we continued." There we continued." There we continued."	Assessment reference date assessed Resident #7 with a score of 15 out of 15. Section ats, Procedures and Programs are range of motion for curveyor reviewed the October of flow record for the look at the flow record for the look at the flow record revealed at restorative nursing for 15, 10/20/15, and 10/22/15. The flow record revealed at restorative nursing only at the look back period-not 7 s. The flow record revealed at restorative nursing only at the look back period-not 7 s. The flow record revealed for 1/12/16 at 1:00 p.m. She does what Resident #7 or restorative, then that should sal." There was no 0/17/15, 10/19/15, 10/21/15, and 10/21/16 at 1:05 p.m. She at the flow of restorative nursing an 1/12/16 at 1:05 p.m. She at the flow of the motes and the MDS and the flow of the only information written at "Current Care Plan"	F 2			

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OCIVIL	TO TOT WEDIOAILE	A MILDICAID SERVICES			OMB NO. 0938-0391	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495320	B. WING		01/13/2016	
	PROVIDER OR SUPPLIER GE HALL CLINTWOOL)		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE CLINTWOOD, VA 24228	E 607 PO BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 278	worksheets did not complicating factors areas that were trig (activities of daily live dehydration, pressuring use. The surveyor intervit (MDS) coordinator or reviewed Section V for each of the trigg were tools and not pustated the worksheet The surveyor inform of nursing, the minimic coordinator and the the above finding or	cion could be found. The CAA include information on s, risks, or any referrals for the gered as care planned (ADL ring), urinary, falls, nutrition, are ulcers and psychotropic sewed the minimum data set on 1/12/16 at 2:00 p.m. She and stated she did have tools ered items but stated these part of the clinical record. She ets were not accurate. The administrator, director mum data set (MDS) regional registered nurse of 1/12/16 at 3:00 p.m. on was provided prior to the	F 2	78	·	
		illed to ensure an accurate MDS) assessment for				
	2/19/10 with diagnos stroke, osteoporosis	nitted to the facility on es of Alzheimer's disease, , dysphagia, anxiety, insomnia, coronary artery				

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) D/	ATE SURVEY OMPLETED	
		495320	B. WING	naverana-rassarias) All the Control of	0	1/13/2016	
	PROVIDER OR SUPPLIER GE HALL CLINTWOOL)		1225	EET ADDRESS, CITY, STATE, ZIP COI 5 CLINTWOOD MAIN STREET, RO NTWOOD, VA 24228	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 278	Continued From pa	ge 13	F 2	278				
	reference date of 12 resident was assess memory deficit (1/12) assistance for decis assessed requiring of 1-2 persons for b dressing, eating, toil Section V for Care A Summary was also failed to identify the information used to	m Data Set (MDS) with a 1/6/15 was reviewed. The sed with long and short term and requiring extensive sion making. The resident was extensive to total assistance ed mobility, transfers, leting, bathing, and hygiene. Area Assessment (CAA) reviewed. The facility staff date and location of the CAA determine the care plan. The was the "current care plan						
	1/12/16 at 10:00 a.m summary. RN#1 statused to determine c	or (RN#1) was interviewed on no. regarding the CAA ated computer reports were are planning, but stated she nere the information was						
	Data Set (MDS) coo consultant were info	irector of nursing, Minimum rdinator, and corporate nurse rmed of the findings during a vey team on 1/12/16 at 4:00						
		ailed to ensure an accurate MDS) assessment for						
	Resident #4 was adr 6/20/14 with diagnos	mitted to the facility on ses of dementia,						

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hypertension, diabetes, stroke,

osteoporosis, anxiety, depression, psychosis,

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Facility ID: VA0109

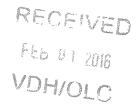
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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0.0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495320	B. WING		MANIFER FOLK IN AND PROVINCE AND REAL PROPERTY AND REAL PROPERTY AND P	0-	1/13/2016	
	PROVIDER OR SUPPLIER BE HALL CLINTWOOL)		12	REET ADDRESS, CITY, STATE, ZIP CODE 25 CLINTWOOD MAIN STREET, ROUT LINTWOOD, VA 24228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 278	Continued From pa gastro-esophageal storm, and coronary	reflux disease, thyrotoxic	F2	278				
	with a reference dat The resident was as term memory deficit assistance for decis assessed requiring	nge Minimum Data Set (MDS) te of 10/9/15 was reviewed. ssessed with long and short (1/1) and requiring moderate tion making. The resident was extensive assistance of 1-2 bility, transfers, dressing, hing, and hygiene.						
	Section V for Care Area Assessment (CAA) Summary was also reviewed. The facility staff failed to identify the date and location of the CAA information used to determine the care plan. The only documentation was the "current care plan continued".							
	The MDS coordinator (RN#1) was interviewed on 1/12/16 at 10:00 a.m. regarding the CAA summary. RN#1 stated computer reports were used to determine care planning, but stated she did not document where the information was obtained.							
The administrator, director of nursing, Minimum Data Set (MDS) coordinator, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 1/12/16 at 4:00 p.m.								
		niled to ensure an accurate MDS) assessment for						

Resident #8 was admitted to the facility on 6/30/14 with diagnoses of dementia, atrial



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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES						M APPROVEL D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		495320	B. WING	; 		0	1/13/2016
NAME OF	PROVIDER OR SUPPLIER			j .	REET ADDRESS, CITY, STATE, ZIP COI	DE	
HERITA	GE HALL CLINTWOOI	D		i .	25 CLINTWOOD MAIN STREET, RO LINTWOOD, VA 24228	UTE 607 PO I	3OX 909
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	anxiety, depression disease, gastro-esc coronary artery disease. The annual Minimureference date of 60 resident was asses: "2" of "15". The resi extensive assistance mobility, transfers, obathing, and hygien Section V for Care A Summary was also failed to identify the information used to only documentation continued". The MDS coordinate 1/12/16 at 10:00 a.m summary. RN#1 staused to determine c did not document whobtained. The administrator, d Data Set (MDS) cooconsultant were info	psion, deep vein thrombosis, psychosis, chronic kidney ophageal reflux disease, and ease. In Data Set (MDS) with a 45/15 was reviewed. The sed with a cognitive score of dent was assessed requiring the of 1-2 persons for bed dressing, eating, toileting,	F	278			
		the facility staff failed to MDS (minimum data set)					



Resident #1 was admitted to the facility on



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	IEDICAID SERVICES				OMB N	IO. 0938-0391
	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	1 (EX)	DATE SURVEY COMPLETED
	495320	B. WING	NHW-H-Contagnilla	Notes and August anni land and and anni anni anni anni anni ann		01/13/2016
NAME OF PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP C	ODE	
HERITAGE HALL CLINTWOOD				NTWOOD, VA 24228	(OO1E 007 FO	POV 909
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
included but not limited to gastroesophageal reflux seizure disorder, anxiety intellectual disabilities. The most recent compres ARD (assessment refered coded the Resident #1 a C, cognitive patterns. See Assessment (CAA) Sum The facility staff had not location of the CAA information of the CAA in	d on 08/02/12. Diagnoses to anemia, hypertension, disease, hyperlipidemia, disease, hyperlipidemia, depression and thensive MDS with an ence date) of 12/04/15 s 12 out of 15 in Section ection V, Care Area mary was also reviewed identified the date and mation used to determine locumentation was the ued". It is interviewed on 1/12/16 he CAA summary. MDS uter reports were used to but stated she did not rmation was obtained. For of nursing, MDS nurse consultant were during a meeting with the at 4:00 p.m. Its provided prior to exit. It is provided to (minimum data set) It to the facility on on 08/12/15. Diagnoses	F2	278			

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hypertension, gastroesophageal reflux disease, benign prostatic hypertrophy, neurogenic bladder,

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CENTERS FOR MEDICARE & MEDICAID SERVICES							O. 0938-0391
STATEMENT OF DEF AND PLAN OF CORF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED
		495320	B. WING	*****************		0.	1/13/2016
NAME OF PROVIDE		D		122	REET ADDRESS, CITY, STATE, ZIP CODE 25 CLINTWOOD MAIN STREET, ROU INTWOOD, VA 24228	# -	
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
The n ARD coded cognit Assess The fallocation the call coording determ docum. The according inform survey. No fur. 9. For ensure assess Reside 10/17/hypert. Alzhein psychological conding conding the coording that the call coording that the coording term of the coordinate term of the coordinat	ent, seizure di chronic obstruct nost recent co (assessment i d the Resident tive patterns. 3 ssment (CAA) acility staff hac on of the CAA are plan. The c ent care plan of MDS coordinat 00 a.m. regard inator stated of mine care plan nent where the dministrator, of inator, and reg ied of the findi y team on 1/12 ther informatic Resident #9, e an accurate sment. ent #9 was ad 14. Diagnoses ension, diabet mer 's diseas	on, arthritis, cerebrovascular sorder, anxiety, depression, ctive pulmonary disease. Imprehensive MDS with an reference date) of 11/06/15 as 15 of 15 in section C, Section V, Care Area Summary was also reviewed. If not identified the date and information used to determine only documentation was the ontinued". For was interviewed on 1/12/16 ding the CAA summary. MDS computer reports were used to aning, but stated she did not be information was obtained. Firector of nursing, MDS gional nurse consultant were ngs during a meeting with the 2/16 at 4:00 p.m. For was provided prior to exit. The facility staff failed to MDS (minimum data set) mitted to the facility on a included but not limited to es mellitus, hyperlipidemia, e, anxiety, depression, gout, hypothyroidism and	F 2	.78			

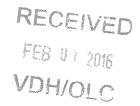
FORM CMS-2567(02-99) Previous Versions Obsolete

The most recent comprehensive MDS with an ARD (assessment reference date) of 09/11/15

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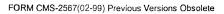
Facility ID: VA0109

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DA	TE SURVEY	
		495320	B. WING	40-000-Ad-June		0-	1/13/2016	
	PROVIDER OR SUPPLIER GE HALL CLINTWOOL)		122	REET ADDRESS, CITY, STATE, ZIP CODE 5 CLINTWOOD MAIN STREET, ROUT INTWOOD, VA 24228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	Χ	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
	cognitive patterns. S Assessment (CAA) The facility staff had location of the CAA the care plan. The of "current care plan of The MDS coordinated at 10:00 a.m. regard coordinator stated of determine care plan document where the The administrator, of coordinator, and reginformed of the finding survey team on 1/12 No further information 10. For Resident #10 ensure an accurate assessment. Resident #10 was an 11/06/15. Diagnoses atrial fibrillation, hypereflux disorder, uring hyperlipidemia, anxiopulmonary disease at The most recent cortain ARD (assessment recoded the Resident spatterns. Section V,	as 01 out of 15 in Section C, Section V, Care Area Summary was also reviewed. It not identified the date and information used to determine only documentation was the ontinued". Or was interviewed on 1/12/16 ding the CAA summary. MDS computer reports were used to ming, but stated she did not a information was obtained. Director of nursing, MDS gional nurse consultant were ngs during a meeting with the 2/16 at 4:00 p.m. On was provided prior to exit. On the facility staff failed to MDS (minimum data set) dmitted to the facility on a included but not limited to pertension, gastroesophageal	F 2	78				



staff had not identified the date and location of the CAA information used to determine the care



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		TO THE CONTROL OF THE	-			JIVID INU.	. 0936-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) DATE SURVEY COMPLETED		
		495320	B. WING	ì		01/	13/2016
NAME OF	PROVIDER OR SUPPLIER		***************************************	STI	REET ADDRESS, CITY, STATE, ZIP CODE		10,2010
HERITA	GE HALL CLINTWOOI	,			25 CLINTWOOD MAIN STREET, ROUTE (LINTWOOD, VA 24228	507 PO BO	OX 909
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 278	Continued From page 19 plan. The only documentation was the "current care plan continued". The MDS coordinator was interviewed on 1/12/16			F 278			
at 10:00 a.m. regardir coordinator stated condinator stated conditions are planning document where the interest and region and region are stated at the coordinator, and region are stated at the coordinator, and region are stated at the coordinator.		ding the CAA summary. MDS computer reports were used to aning, but stated she did not a information was obtained. director of nursing, MDS gional nurse consultant were ings during a meeting with the			F-372		
F 372 Z SS=C F	survey team on 1/12 483.35(i)(3) DISPOS PROPERLY	rvey team on 1/12/16 at 4:00 p.m. 33.35(i)(3) DISPOSE GARBAGE & REFUSE ROPERLY			Corrective Action(s): The area around the dumpsters was cleaned of the trash on the ground at was properly disposed of inside the dumpsters.		
The facility must dispose of garbage and properly. This REQUIREMENT is not met as evid by: Based on observation and staff interview facility staff failed to ensure a clean area the dumpster.		T is not met as evidenced on and staff interview, the			Identification of Corrective Deficie Practice(s) & Corrective Action(s) All other garbage disposal areas have potential to be affected. The Mainte Director and Environmental Service: Director will inspect all garbage stor areas to identify risk. Any/All negate findings will be corrected at time of discovery.	e the enance s rage	
	the findings include: the dumpster area was observed during the solitial tour of the facility conducted 1/12/16 at 1:30 to m. the dietary manager accompanied the surveyor suring the tour. The area around the dumpster has observed to contain a dirty glove on the round directly in front of the dumpster. There ere pieces of trash around the front and right de of the dumpster consisting of paper and			NAMES OF THE PARTY	Systemic Change(s): The facility policy & procedure for t storage and disposal of refuse was reviewed and no changes are warran this time. The Maintenance Director and/or Environmental Services direct will provide in-services to all staff or proper techniques for the collection, storage, and disposal of refuse. The inservice training will include dispos of all refuse inside supplied dumpster and keeping lids closed at all times.	ted at r stor n the	

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 093	38-039
	FOF DEFICIENCIES DEFORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SUF COMPLET	
		495320	B. WING_		01/13/2	2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		.010
HEDITA	SE HALL CLINTWOOL			1225 CLINTWOOD MAIN STREET, ROI	JTE 607 PO BOX 90	19
HENTIA	DE HALL CLINTWOOL	;		CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COM	(X5) MPLETION DATE
F 468	checked often and vicleaned. The administrator, of Data Set (MDS) coordinated consultant were informeeting with the surp.m. 483.70(h)(3) CORR SECURED HANDR	er stated she had the area would assure the area was director of nursing, Minimum ordinator, and corporate nurse formed of the findings during a rey team on 1/12/16 at 4:00 IDORS HAVE FIRMLY AILS	F 37	responsible for maintaining com The Maintenance Director and/o Environmental Services Director complete rounds of dumpster are to monitor and maintain complia refuse on the ground surrounding dumpsters will be corrected imm The results of these rounds will be reported to the Quality Assurance Committee for review, analysis, recommendations for change in f	pliance. r will as daily nce. Any g the ediately. be e & acility e. , 2016	
	by: Based on observatifacility staff failed to secured to the wall of at the entrance to the During a facility walk 1/12/16 beginning at observed loose hand activities office and a Both handrails were below where the har wall. The surveyor in nursing of the above the maintenance states The surveyor showed both loose handrails may have had a smar were purchased.	on and staff interview, the ensure handrails were firmly on 1 of 2 units (left side) and e activities office. It through of the facility on 1:45 p.m., the surveyor drails at the entrance to the at the entrance to room L8. observed to be broken just drails were attached to the informed the director of finding and the DON stated off would be informed. It is not met as evidenced in the entral were attached to the informed the director of finding and the DON stated off would be informed. It is not met as evidenced in the entral were attached to the entrance to the informed the director of finding and the DON stated off would be informed. It is not met as evidenced in the entral were attached to the entrance to the entrance assistant in the stated that the handrails he would take care of the		Identification of Deficient Prace and Corrective Action(s): All other unit handrails had the pot to be affected. The Maintenance of will inspect all handrails througher entire facility to identify areas at a Any/All negative findings will be corrected at time of discovery. Systemic Change(s): The facility policy & procedure for providing a safe, sanitary, and comfortable environment was revand no changes are warranted at the All staff will be inserviced on repand recording maintenance reques for items including handrails that repair or replaced. The environment services staff will inspect hand rais as part of their daily cleaning process.	otential director out the risk. or iewed his time. orting st forms need ental	



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	NO TON WEDIOMILE	A MEDICAID SERVICES	-			MR NO. 0938-0391	1
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
-	demokratika na sa	495320	B. WING			01/13/2016	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		***
UEDITA	CELLALL CLINTWOOF			12	25 CLINTWOOD MAIN STREET, ROUTE 6	07 PO BOX 909	
HERITAL	GE HALL CLINTWOOL	, ;			LINTWOOD, VA 24228		
/VA) 10	SI MMADY CTA	TEMENT OF DEFICIENCIES					_
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
	minimum data set (i regional registered above finding on 1/2 administrator and the that they had misse checked. No further information exit conference on 2 483.75(j)(1) ADMIN The facility must proservices to meet the facility is responsible	he director of nursing, the MDS) coordinator, and the nurse were informed of the 12/16 at 3:00 p.m. Both the director of nursing stated d those handrails when they on was provided prior to the 1/13/16.	F 5	168	throughout the building. Any/all negated findings will be reported to the maintenance director for repair. Monitoring: The Maintenance Director is responsibe for maintaining compliance. The Maintenance Director and/or designee will complete the facility maintenance audit tool monthly to monitor compliant The results of these audits will be reported to the Quality Assurance Committee for review, analysis, recommendations for change in facility policy, procedure, and/or practice. Completion Date: February 26, 2016	ole nce.	
	This REQUIREMEN by: Based on staff inter review, the facility st ordered laboratory to (Resident #5 and Resident #5 and 1/12/16 and 1/12/16. The clinical record of 1/11/16 and 1/12/18/1 included but not limit psychosis, unspecifical gastroesophageal resophagitis, and hyp Resident #5's annual assessment with an (ARD) of 11/13/15 as	T is not met as evidenced view and clinical record aff failed to obtain physician ests for 2 of 16 residents esident #7). d: ailed to obtain a urinalysis or Resident #5. f Resident #5 was reviewed Resident #5 was admitted 3 with diagnoses that ed to pain, unspecified ed intellectual disabilities, flux disease without			Corrective Action(s): Resident #5's attending physician has been notified that the facility failed to obtain a urinalysis with culture and sensitivity as ordered by the physician. A Facility Incident & Accident form ha been completed for the missing labs. Resident #7's attending physician has been notified that the facility failed to obtain a Comprehensive Metabolic Profile as ordered by the physician and drew a Basic metabolic Panel without a physicians order. A Facility Incident & Accident form has been completed for the missing labs.	·	The state of the s





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STATEMEN	IT OF DEFICIENCIES	(VI) DOOMDED/GUDDUEG/GUA	T			1	<u>0. 0936-039 i</u>
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		E CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
		495320	B. WING			01/13/2016	
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		1/13/2010
LICOITA	CE HALL OF BURNING	_			225 CLINTWOOD MAIN STREET, ROUTE 6	07 PO 1	POV non
HERHA	GE HALL CLINTWOOI	U			LINTWOOD, VA 24228	0710	30X 303
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	***************************************	PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
		,		Į	Identification of Deficient Practice(s) -	
F 502	Continued From pa	ge 22	F 5	02	& Corrective Action(s):		
	C Summary Score.	Section H Bladder and Bowel			All other residents who had physician		
	was coded that Res	sident #5 was occasionally			ordered lab tests may have potentially		
	incontinent of urine.				been affected. A 100% audit of all resident's lab orders will be completed	4.0	
	The clinical record r	revealed a physician order		:	identify residents at risk. All negative	ю	
	dated 12/3/15 9A (a	m-morning) and read "Obtain			findings will be corrected at the time of	f	
	a U/A (urinalysis) wi	ith C&S (culture and			discovery. The attending physicians wi	11	
	sensitivity)."				be notified of the missing labs, labs not	:	
	The surveyor review	ved the laboratory section of			obtained timely and labs obtained		
		nd found no results. The			without a physician order. A facility]
		he "Departmental Notes" from			Incident & Accident Form will be		
		17/15. The Departmental			completed.		
	was obtained.	mentation that the urinalysis			Constant CI		
		ed the minimum data set			Systemic Changes: The facility policy and procedure has		
	(MDS) coordinator of	of the above finding on			been reviewed and no changes are		
	1/12/16 at 8:20 a m	At 2:20 p.m. on 1/12/16 the			warranted at this time. The laboratory		į
		ormed the surveyor the			tracking system has been reviewed and		l
	urinalysis had not be				implemented to track and validate that		
		ed the administrator, director			required lab work has been completed		
•	of nursing, the minin	num data set (MDS)			per physician order and policy and		
		regional registered nurse of			procedure. The DON and/or Nurse		•
		1/12/16 at 3:00 p.m.			Consultant will inservice all licensed		
		on was provided prior to the			staff on physician ordered laboratory-		
	exit conference on 1				testing, protocols, & tracking system		
	2. The facility staff fa				used.		
:		abolic profile (CMP) for			Monitoring:		
•	Resident #7.	cm			The DON is responsible for maintaining	,	:
		f Resident #7 was reviewed			compliance. The DON and/or designee	•	
		Resident #7 was admitted			will complete the Facility Lab audit tool	1	
		and readmitted 6/6/12 with			weekly to monitor for compliance. Any		
		ded but not limited to			negative findings will be reported to the		
		ranial hemorrhage, pain, type urine retention, insomnia,			attending physician and disciplinary		
	gastroesophageal re				action will be taken as warranted. The		:
		ation, muscle wasting and			results of these audits will be reported to)	
	atrophy, muscle wea				the Quality Assurance Committee for		
		c kidney disease, kidney			review, analysis, & recommendations fo	r	
		stitis without hematuria, and			change in facility policy, procedure,		
	lack of coordination.	outo without nomatura, and			and/or practice. Completion Date: February 26, 2016		
		,			Completion Date. February 20, 2010		1

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

Event ID: S9YQ11

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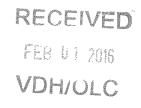
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	21
		495320	B. WING	-		01/13/2016	
	PROVIDER OR SUPPLIER GE HALL CLINTWOOI) ,		12	TREET ADDRESS, CITY, STATE, ZIP CODE 225 CLINTWOOD MAIN STREET, ROUTE 6 LINTWOOD, VA 24228		umations
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID . PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	ν
F 502 Continued From page 23 Resident #7's annual minimum data set (MDS) assessment with an assessment reference date		F 5	502				
	cognitive summary A physician order di "Liver Panel in a.m. CBC (complete bloc metabolic panel) q (CMP (comprehensis 3 months."	assessed Resident #7 with a score of 15 out of 15. ated 5/8/15 at 10:50 a.m. read (morning). DC (discontinue) od count) and BMP (basic (every) month. Start CBC and we metabolic panel) q (every)					
	the clinical record a complete blood cou the results of a BMF surveyor was unable CMP or an order for The surveyor reques	sted the assistance of the		27 000			
	at 1:05 p.m. She re informed the survey done correctly. She instead of a CMP as The surveyor inform of nursing, the minin coordinator and the the above finding on	ed the administrator, director num data set (MDS) regional registered nurse of 1/12/16 at 3:00 p.m.					
F 514 .	exit conference on 1 483.75(I)(1) RES RECORDS-COMPL LE The facility must maresident in accordan standards and practi	intain clinical records on each ce with accepted professional ces that are complete; ted; readily accessible; and	F 5 ⁻		F514 Corrective Action(s): Resident #6's attending physician has been notified of the medication transcription error related to the resider Dilantin order. Resident #6's medicatio orders have been reviewed to ensure all medication orders included the correct medication form, dose, route and time to be dispensed. A facility incident and accident form has been completed for each incident.	on I	

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

Event ID: S9YQ11

Facility ID: VA0109

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		-	C	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495320	B. WING	į		01/13/2016		
NAME OF I	PROVIDER OR SUPPLIER	I control to the second	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE			
t community proper at the	~~	man.		1:	225 CLINTWOOD MAIN STREET, ROUTE 6	307 PO BOX 909		
HERITAG	GE HALL CLINTWOOL			1	CLINTWOOD, VA 24228			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 514	Continued From page 24 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and		F 5	514	Identification of Deficient Practices & Corrective Action(s): All other residents may have potentially been affected. A 100% review of all			
	services provided; t preadmission scree and progress notes			resident's physician orders, MARS, TAR's will be conducted by the DON, Unit Manager, and/or designee to ident residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery and the	ify			
	This REQUIREMEN by: Based on staff inter review, the facility s			applicable at time of discovery and the attending physician notified. A facility Incident & Accident form will be completed for each negative finding.				
		lete and accurate clinical record for 1 of 16			Systemic Change(s): The facility policy and procedure has			
	The findings include	•		been reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the DON and/or				
	For Resident #6, the an accurate entry or summary) and MAF record) for the medi			clinical nurse consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical				
	11/18/05 and readmincluded but not limit	Resident #6 was admitted to the facility on 11/18/05 and readmitted on 08/12/15. Diagnoses included but not limited to anemia, coronary			documentation to include accurate documentation of medical information. Physician Orders, MAR's, TAR's and	·		
	artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, benign prostatic hypertrophy, neurogenic bladder, urinary tract infection, arthritis, cerebrovascular accident, seizure disorder, anxiety, depression, and chronic obstructive pulmonary disease.				ADL records according to the acceptable professional standards and practices.			
	The most recent cor	mprehensive MDS (minimum			RE	CEIVED		
	date) of 11/06/15 co	with an ARD (assessment reference 1/06/15 coded the Resident as 15 of 15			to the state of th	CEIVED 8 0 1 2016 H/OLC		
	in section C, cognitive patterns. The Resident's clinical record was reviewed on				VD	H/OLC		

The Resident's clinical record was reviewed on 01/12/16. It contained a signed and dated POS

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	48 FOR MEDICARE	E & MEDICAID SERVICES	-	***************************************	<u>O</u> I	<u>MB NO.</u>	<u>. 0938-0391</u>	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/13/2016		
		495320			No. of Control of Cont			
NAME OF F	PROVIDER OR SUPPLIER	And the state of t		ST	REET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	SE HALL CLINTWOO!	n	ļ	12	25 CLINTWOOD MAIN STREET, ROUTE 60	07 PO BC	OX 909	
HERITAGE HALL CLINTWOOD				CI	CLINTWOOD, VA 24228			
(X4) ID PREFIX TAG	. (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
	Continued From page 25 with the following entry which read in part "Dilantin 100mg (milligram) capsule 2 tabs + 200mg po (by mouth) every 12 hours". The Resident's MAR (Medication Administration Record) was also reviewed and contained the same entry. The surveyor spoke with the regional nurse consultant and DON (director of nursing) on 01/12/16 at approximately 12:30PM regarding the correct dosage of this medication. The DON (Director of Nursing) confirmed that the correct dosage of the medication was to be 200mg. The regional nurse consultant stated the entries on the POS and MAR contained a typographical error and the (+) should have been an (=), to indicate 2 100mg capsules equaling a total dose of 200mg. The concern of the inaccurate documentation was discussed with the administrative team during a meeting on 01/12/16 at approximately 2:30PM. No further information was provided prior to exit.		F 5	514.	Monitoring: The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will audit physician orders, and MAR/TAR records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. 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: February 26, 2016	o re at n		
:					RECEIV FEB UT 20 VDH/OLG	10		