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

Glenna W. Kennedy, Administrator
Heritage Hall – Clintwood
P.O. Box 909
Clintwood, VA 24228

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HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS
Managed by AMERICAN HEALTHCARE LLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495320	A. BUILDING _____ 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

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F 000	Initial Comments 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 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 000	RECEIVED FEB 01 2016 VDH/OLC	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities: Resident Rights 12 VAC 5-371-240 (C.10)-Cross reference to F155 Resident Behavior and Facility Practices 12 VAC 5-371-330 (A-I)-Cross reference to F221 Resident Assessment 12 VA 5-371-250 (A, D, E)-Cross reference to F278 Dietary Services 12 VAC 5-371-(restaurant regulations)-Cross reference to F372 Administration 12 VAC 5-371-310 (A) - Cross reference to F502 12 VAC 5-371-360 (E.4, 9)-Cross reference to	F 001	**F001** **Resident Rights** **12VAC 5-371-240 (C. 10) Cross reference to F-155** Cross Reference to POC for F Tag- 155 **Resident Behavior and Facility Practice** **12 VAC 5-371-330 (A-I) Cross reference to F-221** Cross Reference to POC for F– 221 **Resident Assessment** **12 VAC 5-371-250 (A, D, E) Cross reference to F-278** Cross Reference to POC for F– 278 **Dietary Services** **12 VAC 5-371-(Restaurant Regulations) Cross reference F-372** Cross Reference to POC for F Tag-F-372	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Glenna Kennedy	Administrator	1-27-2016

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F 001	Continued From Page 1 F514	F 001	**Administration** **12 VAC 5-371-310 (A) Cross reference 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**	

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 01/11/16 through 01/13/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life 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 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	F 155	**F155** **Corrective Action(s):** Resident #12 has had their DDNR form and physician orders reviewed by the attending physician and they have been updated and correctly completed to reflect resident #12's DNR status. An Incident and Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Admission Director will review all resident's medical records and contact all responsible parties for a resuscitation status and advance directives to insure that the proper status has been explained and that written notification has been placed in the medical record.

The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

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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.

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F 155	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the code status and the DDNR (Durable Do Not Resuscitate) order were complete and accurate for 1 of 16 residents (Resident #12). The findings included: The facility staff failed to ensure Resident #12's code status was accurate. Resident #12's DDNR (Durable Do Not Resuscitate) form was incomplete. The surveyor reviewed Resident #12's clinical record on 1/13/16. Resident #12 was admitted to the facility 10/28/15 and readmitted 12/31/15 with diagnoses that included but not limited to end stage renal failure with dialysis, obstructive uropathy with stent, major depression, urinary tract infection, protein-calorie malnutrition, venous insufficiency with right lower leg ulcer, hypercalcemia with parathyroid tumor, and anemia. Resident #12's 5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/4/15 assessed the cognitive status as 15 out of 15 in Section C Summary Score. The clinical record contained a Virginia Department of Health Durable Do Not Resuscitate (DDNR) order dated 1/4/16. The DDNR form included in the clinical record stated in part: "I further certify (must check 1 or 2): 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision... If you checked 2 above, check A, B, or C below:	F 155	**Systemic Change(s);** Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director has been inserviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record. **Monitoring:** The Admission Director is responsible for maintaining compliance. The Admission Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date: February 26, 2016**	

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F 155	Continued From page 2 A. While capable of making an informed decision, the patient has executed a written advanced directive... B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf "... C. The patient has not executed a written advanced directive..." There were no checks in any of the boxes on the DDNR form. The section at the bottom of the DDNR form had been signed by the physician and the resident. The form was dated 1/4/16. A review of the hospital discharge orders dated 12/31/15 and the December 2015 admission physician's orders at the facility identified Resident #12 as "DNR-Do Not Resuscitate". However, the January 2016 physician order sheet signed 1/4/16 read "Full Code." The surveyor interviewed the director of nursing and the regional registered nurse on 1/13/16 at 9:10 a.m. The director of nursing stated she would take care of the discrepancy. The surveyor informed the administrator, the director of nursing, the minimum data set (MDS) coordinator, and the regional registered nurse of the above finding on 1/13/16 at 10:45 a.m. No further information was provided prior to the exit conference on 1/13/16.	F 155		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221	**F221** **Corrective Action(s):** Resident #10 has been reassessed by nursing, therapy, and the attending physician for the need and use of a lap buddy while in the chair. Resident #10's care plan has been revised to reflect changes made to include using a lap buddy while in chair. The responsible party was notified and explained the risks and benefits of using a lap buddy while in the chair and consent was obtained. A Facility Incident & Accident form was completed for this incident.	

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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 facility conducted a 100% review of all residents currently utilizing restraints to identify other residents at risk. All residents identified at risk will be corrected at time of discovery. The results of this audit were reviewed by the Risk Management Committee to ensure proper diagnosis, medical necessity, consent for use and that the least restrictive appliance is being used. **Systemic Change(s):** The facility Policy and Procedure for Restraints has been reviewed and no changes are warranted at this time. Nursing staff will be inserviced on obtaining consent for use of a restraint, the proper use of restraints and the need for supporting medical diagnosis /medical symptoms to justify the use of the restraints. The Risk Management Committee will review all restraints weekly to verify they have an appropriate medical diagnosis /symptom that warrant the use of the restraint and that consent has been obtained. The committee will also make recommendations to staff for restraint reductions and the least restrictive alternatives. This will be indicated on the risk management committee meeting minutes.	

This REQUIREMENT is not met as evidenced by:
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 as 99 in Section C, cognitive patterns. Section G, functional status coded 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 observed at approximately 3 PM, during initial tour of the facility, sitting near the nurse ' s station. Resident #10 was noted to have a "lap buddy" cushion in place over her lap in wheelchair. The lap buddy was attached to wheelchair by Velcro straps.
Surveyor spoke with CNA (certified nurse's aide) #1 on 01/11/16 at approximately 3:30 PM regarding Resident #10. CNA #1 stated to

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F 221	Continued From page 4 surveyor that Resident #10 could remove lap buddy if she wanted to. Surveyor asked CNA #1 what was the purpose of the lap buddy, and CNA #1 stated, "to keep her from falling out of her chair when she leans too far over" . Surveyor spoke with LPN (licensed practical nurse) #1 on 01/11/16 at approximately 3:45PM regarding Resident #10. LPN #1 stated Resident #10 could remove lap buddy by herself. Surveyor checked the straps on the lap buddy and the Velcro was firmly attached to itself and difficult to pull loose. Surveyor asked Resident #10 to remove the lap buddy. Resident smiled at surveyor and raised the lap buddy up and down, but did not remove it. Resident #10's clinical record was reviewed on 01/12/16. The physician order summary was reviewed and the surveyor could not locate a physician's order for use of lap buddy. Surveyor could not locate any type of assessment indicating a need for lap buddy, any indication that any type of monitoring was being provided while lap buddy was in use, or consent for use of restraint. Resident #10's CCP (comprehensive care plan) was reviewed and it contained no information regarding the use of lap buddy. Surveyor spoke with DON (director of nursing) on 01/12/16 at 11:15 AM, regarding Resident's use of lap buddy. The DON was asked to accompany surveyor to observe Resident #10 at this time. Resident #10 was observed seated in wheelchair at nurses' station. Lap buddy was attached to wheelchair and hanging loose down one side. DON stated that the lap buddy was used as a safety measure to prevent Resident from falling forward from chair. The DON provided the surveyor with a policy entitled "Restraint Utilization and Reduction"	F 221	**Monitoring:** The DON is responsible for compliance. Residents utilizing restraints will be reviewed weekly in risk management to monitor compliance. The audit findings at the Risk Management meeting will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: February 26, 2016**	

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F 221	Continued From page 5	F 221		

which read in part:
"POLICY: Restraint Utilization and Reduction
The goal of ....(company name omitted) is to provide a restraint free environment for all Residents .....When safety devices are necessary to help a Resident reach his or her maximum level of functional independence, we will monitor the effectiveness on a continuous basis.
If the need for a safety device is indicated a physician's order must follow.
PURPOSE: A restraint is defined as any manual method or device attached or adjacent to an individual that cannot be easily removed by the resident and restricts freedom of movement or normal access to one's body.
PROCEDURE:
1. Complete the Restraint Need Assessment For with the participation of the interdisciplinary team upon admission.
2. The Resident and/or responsible party will be informed of the risks and benefits for restraint use as outlined on the Safety Device Consent Form.
3. .....
4. Prior to implementation the team must ensure that consent is obtained from Resident/responsible party and documented accordingly.
5. ... ...
6. Careful monitoring of the Resident's needs, comfort and well-being through 30-minute checks and every one (1) hour releases for at least ten (10) minutes
7. Documentation is essential.
8. ... ...
9. All restraints/safety devices will be reviewed minimally quarterly for possible elimination and/or reduction in use.
DOCUMENTATION
Any Resident utilizing a restraint will have the

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F 221	Continued From page 6 following documentation on the physician's order: 1. Type of restraint. 2. Medical diagnosis/symptom requiring restraint use. 3. Specific check/release time frames of 30 minute checks and 1 hour releases for 10 minutes with supervision. Any Resident utilizing a restraint will have the following documentation on the Resident's ADL (activities of daily living) sheet: 1. Type of restraint 2. Restraint checked, released and reapplied." The use of the lap buddy without a physician's order, consent, assessment or monitoring was discussed with the administrative team on 01/12/16 at approximately 1450. No further information provided prior to exit.	F 221		
F 278 SS=B	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is	F 278	**F278** **Corrective Action(s):** Resident #3's Quarterly MDS assessment with an ARD of 11/27/2015 was reviewed by the RCC and a modification was completed to accurately code and complete section O of the quarterly MDS to reflect the correct Restorative Nursing that was performed. Resident #3's Significant Change Assessment with an ARD date of 9/22/15 was reviewed and a Modification was completed to accurately code section V of the Significant Change Assessment. A facility Incident & Accident form was completed for this incident.	

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F 278	Continued From page 7 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) assessment for 10 of 16 residents (Resident #3, Resident #5, Resident #7, Resident #2, Resident #4, Resident #8, Resident #1, Resident #6, Resident #9, and Resident #10). The findings included: 1. The facility staff failed to accurately code restorative nursing and failed to accurately complete Section V for Resident #3. The CAA (Care Area Assessments) worksheets were not completed. Resident #3's clinical record was reviewed 1/11/16 and 1/12/16. Resident #3 was admitted to the facility 8/1/14 and readmitted 11/18/15 with diagnoses that included but not limited to muscle wasting and atrophy, muscle weakness, Type 2 Diabetes Mellitus, shortness of breath, unstageable pressure ulcer left ankle, transient ischemic attacks, morbid obesity, hypertension, hyperkalemia, dysphagia, pain and osteoarthritis, gastroparesis, and gastroesophageal reflux disease. (a). The facility staff failed to accurately code	F 278	Resident #7's Annual Assessment with an ARD date of 10/23/15 was reviewed and a Modification was completed to accurately code sections O for restorative Nursing and section V of the Annual Assessment. A facility Incident & Accident form was completed for this incident. Resident #1, #2, #4, #5, #6, #8, #9 & #10 have had their most recent Comprehensive MDS assessment reviewed by the RCC and a modification was completed for each one to accurately code and complete section V of their most recent Comprehensive MDS Assessment. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the RCC and/or designee to ensure that MDS sections V and section O – restorative nursing are assessed and coded correctly. All negative findings will be reported to the RCC for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.	

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F 278	Continued From page 8 Resident #3's restorative nursing. The surveyor reviewed the quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/27/15. Resident #3 was assessed with a cognitive summary score of 15 out of 15 in Section C Summary Score. Section O Special Treatments, Procedures, and Programs was also reviewed. Resident #3 was coded for range of motion (passive) for 7 days, range of motion (active) for 7 days, transfer training (7 days) and eating/swallowing training (7 days). A review of the November 2015 restorative care flow record for the look back period (11/21/15 through 11/27/15) revealed Resident #3 received restorative nursing for active range of motion (feed self) for 7 days, transfers from bed/chair for 7 days, combing hair for 7 days, active range of motion to both right and left upper and lower extremities every day during the look back period for 7 days, and nu-step (omnicycle) 7 days. The surveyor was unable to locate where Resident #3 received passive range of motion during the look back period. The surveyor interviewed the restorative certified nursing assistant (R.C.N.A.) #1 on 1/12/16 at 9:30 a.m. The restorative C.N.A. #1 reviewed the November 2015 restorative flow record and stated Resident #3 didn't need passive range of motion in November. She stated everything that was done was active. The surveyor interviewed licensed practical nurse #3 on 1/12/16 at 1:05 p.m. She stated she should have checked the record herself instead of relying on the information provided by the restorative aide. (b) The surveyor reviewed the significant change in assessment minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/22/15. Resident #3 was assessed	F 278	**Systemic Change(s):** The Resident Interdisciplinary Care Team have been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include sections V and O of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: February 26, 2016**	

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with a cognitive summary score of 15 out of 15 in Section C Summary Score. Section V [CAAs (Care Area Assessment) and Care Planning] was reviewed. The only information written in the last column read "Current Care Plan Continued." There was no information documented where the date and location related to the CAA information could be found. The CAA worksheets did not include information on complicating factors, risks, or any referrals for the areas that were triggered as care planned [cognitive, communication, ADL (activities of daily living), urinary, behaviors, falls, nutrition, dehydration, and pressure ulcers].
The surveyor interviewed the minimum data set (MDS) coordinator on 1/12/16 at 2:00 p.m. She reviewed Section V and stated she did have tools for each of the triggered items but stated these were tools and not part of the clinical record. She stated the worksheets were not accurate.
The surveyor informed the administrator, director of nursing, the minimum data set (MDS) coordinator and the regional registered nurse of the above finding on 1/12/16 at 3:00 p.m.
No further information was provided prior to the exit conference on 1/13/16.
2. The facility staff failed to ensure Section V of the minimum data set (MDS) assessment was accurate. The date and location where information could be found to support the triggered items for the care plan was not completed for Resident #5.
The clinical record of Resident #5 was reviewed 1/11/16 and 1.12/16. Resident #5 was admitted to the facility 12/18/13 with diagnoses that included but not limited to pain, unspecified psychosis, unspecified intellectual disabilities, gastroesophageal reflux disease without esophagitis, and hypertension.
Resident #5's annual minimum data set (MDS)

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assessment with an assessment reference date (ARD) of 11/13/15 assessed the resident with a cognitive summary score of 6 out of 15 in Section C Summary Score. Section V was reviewed. Triggered areas marked were: cognitive loss, ADL (activities of daily living), urinary, falls, nutrition, pressure ulcers, and psychotropic drug use. The location and date of CAA information read "Current Care Plan Continued 11/14/15." The area did not include the date or location of the information to support the triggered care plan concerns. The CAA worksheets had no documentation where to locate information for the triggered areas.

The surveyor interviewed the minimum data set (MDS) coordinator on 1/12/16 at 2:00 p.m. She reviewed Section V and stated she did have tools for each of the triggered items but stated these were tools and not part of the clinical record. She stated the worksheets were not accurate.

The surveyor informed the administrator, director of nursing, the minimum data set (MDS) coordinator and the regional registered nurse of the above finding on 1/12/16 at 3:00 p.m.

No further information was provided prior to the exit conference on 1/13/16.

3. The facility staff failed to accurately code restorative nursing and failed to complete Section V accurately for Resident #7.

The clinical record of Resident #7 was reviewed 1/11/16 and 1/12/16. Resident #7 was admitted to the facility 10/7/08 and readmitted 6/6/12 with diagnoses that included but not limited to non-traumatic intracranial hemorrhage, pain, type 2 diabetes mellitus, urine retention, insomnia, gastroesophageal reflux disease without esophagitis, constipation, muscle wasting and atrophy, muscle weakness, age related osteoporosis, chronic kidney disease, kidney

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stone, dysphagia, cystitis without hematuria, and lack of coordination.
Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/23/15 assessed Resident #7 with a cognitive summary score of 15 out of 15. Section O Special Treatments, Procedures and Programs coded 7 days of active range of motion for Resident #7. The surveyor reviewed the October 2015 restorative care flow record for the look back period 10/17/15 through 10/23/15. Documentation on the flow record revealed Resident #7 received restorative nursing for "Nu-step" on 10/18/15, 10/20/15, and 10/22/15. Resident #7 received restorative nursing only three (3) days during the look back period-not 7 as coded on the MDS.
The surveyor interviewed the restorative certified nursing assistant #1 on 1/12/16 at 1:00 p.m. She stated "Resident #7 does what Resident #7 wants. If we don't do restorative, then that should be charted as a refusal." There was no documentation for 10/17/15, 10/19/15, 10/21/15, or 10/23/15.
The surveyor interviewed licensed practical nurse #3 concerning the coding of restorative nursing on the annual MDS on 1/12/16 at 1:05 p.m. She reviewed the restorative notes and the MDS and stated she should have checked the documentation herself and not listened to what the aide had told her.
(b). The facility staff failed to ensure Section V was complete and accurate for Resident #7.
A review of Section V [CAAs (Care Area Assessment) and Care Planning] revealed for each triggered item, the only information written in the last column read "Current Care Plan Continued." There was no information documented where the date and location related

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to the CAA information could be found. The CAA worksheets did not include information on complicating factors, risks, or any referrals for the areas that were triggered as care planned (ADL (activities of daily living), urinary, falls, nutrition, dehydration, pressure ulcers and psychotropic drug use.
The surveyor interviewed the minimum data set (MDS) coordinator on 1/12/16 at 2:00 p.m. She reviewed Section V and stated she did have tools for each of the triggered items but stated these were tools and not part of the clinical record. She stated the worksheets were not accurate.
The surveyor informed the administrator, director of nursing, the minimum data set (MDS) coordinator and the regional registered nurse of the above finding on 1/12/16 at 3:00 p.m.
No further information was provided prior to the exit conference on 1/13/16.

4. The facility staff failed to ensure an accurate Minimum Data Set (MDS) assessment for Resident #2.

Resident #2 was admitted to the facility on 2/19/10 with diagnoses of Alzheimer's disease, stroke, osteoporosis, dysphagia, anxiety, depression, anemia, insomnia, coronary artery

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disease.

The annual Minimum Data Set (MDS) with a reference date of 11/6/15 was reviewed. The resident was assessed with long and short term memory deficit (1/1) and requiring extensive assistance for decision making. The resident was assessed requiring extensive to total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, 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.

5. The facility staff failed to ensure an accurate Minimum Data Set (MDS) assessment for Resident #4.

Resident #4 was admitted to the facility on 6/20/14 with diagnoses of dementia, hypertension, diabetes, stroke, osteoporosis,anxiety, depression, psychosis,

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gastro-esophageal reflux disease, thyrotoxic storm, and coronary artery disease.

The significant change Minimum Data Set (MDS) with a reference date of 10/9/15 was reviewed. The resident was assessed with long and short term memory deficit (1/1) and requiring moderate assistance for decision making. The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, 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.

6. The facility staff failed to ensure an accurate Minimum Data Set (MDS) assessment for Resident #8.

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

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fibrillation, hypertension, deep vein thrombosis, anxiety, depression, psychosis, chronic kidney disease, gastro-esophageal reflux disease, and coronary artery disease.

The annual Minimum Data Set (MDS) with a reference date of 6/5/15 was reviewed. The resident was assessed with a cognitive score of "2" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, 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.

7. For Resident #1, the facility staff failed to ensure an accurate MDS (minimum data set) assessment.

Resident #1 was admitted to the facility on

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03/20/07 and readmitted on 08/02/12. Diagnoses included but not limited to anemia, hypertension, gastroesophageal reflux disease, hyperlipidemia, seizure disorder, anxiety, depression and intellectual disabilities.

The most recent comprehensive MDS with an ARD (assessment reference date) of 12/04/15 coded the Resident #1 as 12 out of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified 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 was interviewed on 1/12/16 at 10:00 a.m. regarding the CAA summary. MDS coordinator 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, MDS coordinator, and regional nurse consultant were informed of the findings during a meeting with the survey team on 1/12/16 at 4:00 p.m.

No further information was provided prior to exit.

8. For Resident #6, the facility staff failed to ensure an accurate MDS (minimum data set) assessment.

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 artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, benign prostatic hypertrophy, neurogenic bladder,

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urinary tract infection, arthritis, cerebrovascular accident, seizure disorder, anxiety, depression, and chronic obstructive pulmonary disease.

The most recent comprehensive MDS with an ARD (assessment reference date) of 11/06/15 coded the Resident as 15 of 15 in section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified 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 was interviewed on 1/12/16 at 10:00 a.m. regarding the CAA summary. MDS coordinator 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, MDS coordinator, and regional nurse consultant were informed of the findings during a meeting with the survey team on 1/12/16 at 4:00 p.m.

No further information was provided prior to exit.

9. For Resident #9, the facility staff failed to ensure an accurate MDS (minimum data set) assessment.

Resident #9 was admitted to the facility on 10/17/14. Diagnoses included but not limited to hypertension, diabetes mellitus, hyperlipidemia, Alzheimer ' s disease, anxiety, depression, psychotic disorder, gout, hypothyroidism and gastroesophageal reflux disease.
The most recent comprehensive MDS with an ARD (assessment reference date) of 09/11/15

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coded the Resident as 01 out of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified 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 was interviewed on 1/12/16 at 10:00 a.m. regarding the CAA summary. MDS coordinator 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, MDS coordinator, and regional nurse consultant were informed of the findings during a meeting with the survey team on 1/12/16 at 4:00 p.m.

No further information was provided prior to exit.

10. For Resident #10, the facility staff failed to ensure an accurate MDS (minimum data set) assessment.

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 with an ARD (assessment reference date) of 11/13/15 coded the Resident as 99 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care

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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 at 10:00 a.m. regarding the CAA summary. MDS coordinator 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, MDS coordinator, and regional nurse consultant were informed of the findings during a meeting with the survey team on 1/12/16 at 4:00 p.m.	F 278		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure a clean area around the dumpster. The findings include: The dumpster area was observed during the initial tour of the facility conducted 1/12/16 at 1:30 p.m. The dietary manager accompanied the surveyor during the tour. The area around the dumpster was observed to contain a dirty glove on the ground directly in front of the dumpster. There were pieces of trash around the front and right side of the dumpster consisting of paper and	F 372	**F-372** **Corrective Action(s):** The area around the dumpsters was cleaned of the trash on the ground and it was properly disposed of inside the dumpsters. **Identification of Corrective Deficient Practice(s) & Corrective Action(s):** All other garbage disposal areas have the potential to be affected. The Maintenance Director and Environmental Services Director will inspect all garbage storage areas to identify risk. Any/All negative findings will be corrected at time of discovery. **Systemic Change(s):** The facility policy & procedure for the storage and disposal of refuse was reviewed and no changes are warranted at this time. The Maintenance Director and/or Environmental Services director will provide in-services to all staff on the proper techniques for the collection, storage, and disposal of refuse. The inservice training will include disposing of all refuse inside supplied dumpsters and keeping lids closed at all times.	

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plastic.

The dietary manager stated she had the area checked often and would assure the area was cleaned.

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.

F 468 SS=D 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS

The facility must equip corridors with firmly secured handrails on each side.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, the facility staff failed to ensure handrails were firmly secured to the wall on 1 of 2 units (left side) and at the entrance to the activities office.
During a facility walk through of the facility on 1/12/16 beginning at 1:45 p.m., the surveyor observed loose handrails at the entrance to the activities office and at the entrance to room L8. Both handrails were observed to be broken just below where the handrails were attached to the wall. The surveyor informed the director of nursing of the above finding and the DON stated the maintenance staff would be informed.
The surveyor showed the maintenance assistant both loose handrails. He stated the handrails may have had a small break in them when they were purchased. He stated that the handrails were not that old but he would take care of the

F 372

Monitoring:
The Environmental Services Director is responsible for maintaining compliance. The Maintenance Director and/or Environmental Services Director will complete rounds of dumpster areas daily to monitor and maintain compliance. Any refuse on the ground surrounding the dumpsters will be corrected immediately. The results of these rounds 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

F 468

F 468
Corrective Action(s):
The handrails identified during the survey on Left Side Unit have been repaired.

Identification of Deficient Practice(s) and Corrective Action(s):
All other unit handrails had the potential to be affected. The Maintenance director will inspect all handrails throughout the entire facility to identify areas at risk. 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 reviewed and no changes are warranted at this time. All staff will be inserviced on reporting and recording maintenance request forms for items including handrails that need repair or replaced. The environmental services staff will inspect hand rails daily as part of their daily cleaning process

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	495320	A. BUILDING _____ 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

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F 468 Continued From page 21

problem.
The administrator, the director of nursing, the minimum data set (MDS) coordinator, and the regional registered nurse were informed of the above finding on 1/12/16 at 3:00 p.m. Both the administrator and the director of nursing stated that they had missed those handrails when they checked.
No further information was provided prior to the exit conference on 1/13/16.

F 502 SS=D 483.75(j)(1) ADMINISTRATION

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory tests for 2 of 16 residents (Resident #5 and Resident #7).
The findings included:
1. The facility staff failed to obtain a urinalysis ordered on 12/3/15 for Resident #5.
The clinical record of Resident #5 was reviewed 1/11/16 and 1/12/16. Resident #5 was admitted to the facility 12/18/13 with diagnoses that included but not limited to pain, unspecified psychosis, unspecified intellectual disabilities, gastroesophageal reflux disease without esophagitis, and hypertension.
Resident #5's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/13/15 assessed the resident with a cognitive summary score of 6 out of 15 in Section

F 468 throughout the building. Any/all negative findings will be reported to the maintenance director for repair.

Monitoring:
The Maintenance Director is responsible for maintaining compliance. The Maintenance Director and/or designee will complete the facility maintenance audit tool monthly to monitor compliance. 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

F 502

F502
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 has 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.

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F 502	Continued From page 22 C Summary Score. Section H Bladder and Bowel was coded that Resident #5 was occasionally incontinent of urine. The clinical record revealed a physician order dated 12/3/15 9A (am-morning) and read "Obtain a U/A (urinalysis) with C&S (culture and sensitivity)." The surveyor reviewed the laboratory section of the clinical record and found no results. The surveyor reviewed the "Departmental Notes" from 12/3/15 through 12/17/15. The Departmental Notes had no documentation that the urinalysis was obtained. The surveyor informed the minimum data set (MDS) coordinator of the above finding on 1/12/16 at 8:20 a.m. At 2:20 p.m. on 1/12/16 the MDS coordinator informed the surveyor the urinalysis had not been obtained. The surveyor informed the administrator, director of nursing, the minimum data set (MDS) coordinator and the regional registered nurse of the above finding on 1/12/16 at 3:00 p.m. No further information was provided prior to the exit conference on 1/13/16. 2. The facility staff failed to obtain a comprehensive metabolic profile (CMP) for Resident #7. The clinical record of Resident #7 was reviewed 1/11/16 and 1/12/16. Resident #7 was admitted to the facility 10/7/08 and readmitted 6/6/12 with diagnoses that included but not limited to non-traumatic intracranial hemorrhage, pain, type 2 diabetes mellitus, urine retention, insomnia, gastroesophageal reflux disease without esophagitis, constipation, muscle wasting and atrophy, muscle weakness, age related osteoporosis, chronic kidney disease, kidney stone, dysphagia, cystitis without hematuria, and lack of coordination.	F 502	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who had physician ordered lab tests may have potentially been affected. A 100% audit of all resident's lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs, labs not obtained timely and labs obtained without a physician order. A facility Incident & Accident Form will be completed. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed and implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The DON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will complete the Facility Lab audit tool weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. 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**	

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F 502	Continued From page 23 Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 10/23/15 assessed Resident #7 with a cognitive summary score of 15 out of 15. A physician order dated 5/8/15 at 10:50 a.m. read "Liver Panel in a.m. (morning). DC (discontinue) CBC (complete blood count) and BMP (basic metabolic panel) q (every) month. Start CBC and CMP (comprehensive metabolic panel) q (every) 3 months." The surveyor reviewed the laboratory section of the clinical record and found the results of the complete blood count done 11/16/15 as well as the results of a BMP done 11/16/15. The surveyor was unable to find the results for the CMP or an order for the BMP. The surveyor requested the assistance of the minimum data set (MDS) coordinator on 1/12/16 at 1:05 p.m. She reviewed the clinical record and informed the surveyor that was the only lab not done correctly. She stated a BMP was done instead of a CMP as ordered. The surveyor informed the administrator, director of nursing, the minimum data set (MDS) coordinator and the regional registered nurse of the above finding on 1/12/16 at 3:00 p.m. No further information was provided prior to the exit conference on 1/13/16.	F 502		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	**F514** **Corrective Action(s):** Resident #6's attending physician has been notified of the medication transcription error related to the residents Dilantin order. Resident #6's medication 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.	

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F 514	Continued From page 24	F 514	**Identification of Deficient Practices & Corrective Action(s):**	

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 16 Residents, Resident #6.

The findings included:

For Resident #6, the facility staff failed to ensure an accurate entry on the POS (physician's order summary) and MAR (medication administration record) for the medication Dilantin

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 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.

The most recent comprehensive MDS (minimum data set) with an ARD (assessment reference date) of 11/06/15 coded the Resident as 15 of 15 in section C, cognitive patterns.

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

All other residents may have potentially been affected. A 100% review of all resident's physician orders, MARS, TAR's will be conducted by the DON, Unit Manager, and/or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery and the attending physician notified. A facility Incident & Accident form will be completed for each negative finding.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the DON and/or 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 documentation to include accurate documentation of medical information, Physician Orders, MAR's, TAR's and ADL records according to the acceptable professional standards and practices.

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F 514	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 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**	