Our family exists to care for yours.

H eritage Hall – Clintwood • 1225 Clintwood Main Street • P.O. Box 909 • Clintwood, VA 24228 (P) 276.926.4693 • (F) 276.926.9128

Jamuary 9, 2017

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

Mr. Miller,

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

Sincerely,

Glenna Kennedy

Administrator

RECEIVED
JAN 12 2017 VDHIOLC





COMMONWEALTH of VIRGINIA

Department of Health

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

Office of Licensure and Certification

TYY 7-1-1 OR 1-800-828-1120 9960 Mayland Drive, Suite 401 Henrico, Virginia 23233-1485 Fax (804) 527-4502

December 27, 2016

Ms. Glenna Kennedy, Administrator Heritage Hall Clintwood 1225 Clintwood Main Street Route 607 P.O. Box 909 Clintwood, VA 24228

RE: Heritage Hall Clintwood

Provider Number 495320

Dear Ms. Kennedy:

An unannounced standard survey, ending December 15, 2016, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations.

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

Survey Results

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



Ms. Glenna Kennedy, Administrator December 27, 2016 Page 2

This survey found that your facility was not in substantial compliance with the participation requirements. The most serious deficiency in your facility was a pattern deficiency that constitutes no actual harm with potential for more than minimal harm that is not immediate jeopardy (S/S of E), as evidenced by the attached CMS-2567L, whereby corrections are required.

Plan of Correction (PoC)

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

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

To be considered acceptable, the PoC must:

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

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

Informal Dispute Resolution

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

To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to: Director, Division of Long Term Care, Office of Licensure and Certification, 9960 Mayland Drive, Suite 401, Richmond, Virginia 23233. To be considered, the IDR request must follow the IDR guidelines and be received at the Office within 10 calendar days of your receipt of the enclosed survey findings.

An incomplete informal dispute resolution process will not delay the effective date of the imposition of any enforcement actions.

Ms. Glenna Kennedy, Administrator December 27, 2016 Page 3

Recommended Remedies

Based on the deficiencies cited during the survey, under Subpart F of 42 CFR Part 488 the following remedies may be imposed by the Centers for Medicare and Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency (DMAS):

- Pursuant to §488.408(c)
 - Directed Plan of Correction (PoC) (§488.424).
 - State monitoring (§488.422).
 - Directed In-Service Training (§488.425).
- Pursuant to §488.408(d)
 - Denial of payment for new admissions (§488.417).
 - Denial of payment for all individuals (§488.418).
 - Civil Money Penalty, \$50 \$3,000 per day (§488.430, §488.438), effective on the survey ending date,
- Civil money penalties of \$1,000 \$10,000 per instance of noncompliance.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the noncompliance may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Please note: This survey cover letter does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services or the Virginia Department of Medical Assistance Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination. If you do not achieve substantial compliance within three (3) months after the last day of the survey identifying noncompliance, §488.417(b) requires the denial of payment for new Medicare or Medicaid admissions. If substantial compliance is not attained within six months from the last day of the survey, §488.412(b) provides that "CMS will and the State must terminate the facility's provider agreement."

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

Survey Response Form

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

December 27, 2016 Page 4

If you have any questions concerning this letter, please contact me at (804) 367-2100.

Sincerely,

Re- 12. Mille

Rodney L. Miller, LTC Supervisor Division of Long Term Care

Enclosure

cc: Joann Atkins, D M A S (Sent Electronically)

PRINTED: 01/05/2017 FORM APPROVED

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES					RM APPI		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	NO. 0938 TE SURVE MPLETED		
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F 000	INITIAL COMMENTS		F	000					
	survey was conducted 12/15/16. Corrections compliance with 42 Ci Term Care requirement survey/report will follo	s are required for FR Part 483 Federal Long nts. The Life Safety Code w.		A contraction of the contraction					
F 272 SS=D	86 at the time of the s consisted of 16 currer (Residents #1 through record reviews (Residents #3.20(b)(1) COMPREASSESSMENTS The facility must conduct a comprehensive, according to the second reproducible assessments	#15 and #20) and 4 closed ents #16 through #19). EHENSIVE uct initially and periodically urate, standardized		272	F272 Corrective Action(s): Resident #4 has had their Care Area Assessment Summary and Care Area worksheets revised to reflect the loca of the of documentation to support th care plan decisions.	ition			
		ent's needs, using the enstrument (RAI) specified essment must include at egraphic information; tterns; g; id structural problems; health conditions;			Identification of Deficient Practices Corrective Action(s): All other residents may have potential affected. A 100% review of all residents most current comprehensive MDS assessments and the Care Area Assessment Summary's will be comply the RCC to identify residents affected will have their Comprehensive MDS assessments and Care Area Assessment Summary's corrected at time of discover and their comprehensive care plans updated.	ally ent's pleted cted.	STOTION STORY	2.000	

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

Electronically Signed Almma Kinnilla

Administrator

(X6) DATE 1-9-2017

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.

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

Event ID: 4K1G11

Facility ID: VA0109

If continuation sheet Page 1 of 47

PRINTED: 01/05/2017 FORM APPROVED OMB NO. 0938-0391

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F 272	Activity pursuit; Medications; Special treatments ar Discharge potential; Documentation of sur the additional assess areas triggered by the Data Set (MDS); and Documentation of par This REQUIREMENT by: Based on staff interv review the facility staff and accurate Care Ar (CAA) for 1 of 20 Res The findings included For Resident #4 the fraccurately name the of (care area assessment Resident #4 was admontal of the companion of t	mmary information regarding ment performed on the care expense completion of the Minimum eticipation in assessment. The is not met as evidenced liew and clinical record failed to ensure a complete ea Assessment Summary sidents, Resident #4. Exactly staff failed to date and location of CAA and documentation. Solution of the Minimum eticipation in assessment.	F 27:	Systemic Change(s): The facility policy and procedure was reviewed and no changes are warrant this time. The regional nurse consultated will inservice the Resident Care Coordinator's and the interdisciplinar Care Plan Team on accurately completed the Care Area Assessment Summary. Will include accurate documentation indicating the date and location of documentation describing each reside clinical status and other factors that impact care planning. Monitoring: The RCC is responsible for maintain compliance. The RCC will complete MDS audit tool weekly coinciding withe MDS calendar to monitor for compliance. Any/all negative finding will be reported to the RCC and the latt the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in poliprocedure, and/or facility practice. Completion Date: January 29, 2017	ed at nt y etely This ent's con ee ee			

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

Event ID: 4K1G11

Facility ID: VA0109

If continuation sheet Page 2 of 47



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				SURVEY PLETED
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F 272 F 281 SS=D	area assessment, wa had not identified the CAA information used plans. The only docur plan continued". The concern of the m CAA's was discussed during a meeting on 1 1245. No further information	e patterns. Section V, care s reviewed. The facility staff date and location of the d to determine the care mentation was "current care dissing information on the with the administrative staff 2/15/16 at approximately a was provided prior to exit. CES PROVIDED MEET	F 2			
	must meet profession This REQUIREMENT by: Based on staff intervi and clinical record rev follow established pro nursing practice for the medications for 1 of 20 The findings included: For Resident #3 the fa acting insulin, Toujeo, member and without in Resident #3 was admit 06/14/06 and readmitting	e administration of D Residents, Resident #3. cility staff held the long at the request of a family otifying the physician. tted to the facility on ed on 03/14/13. Diagnoses d to anemia, hypertension,		Resident #3's attending physician habeen notified that the facility staff did administer insulin per physician order held resident #3's insulin without notifying the attending physician. Resident #3's physician order insuling been reviewed to ensure all medication orders are accurate. A Facility Incide Accident Form was completed for the incidents. Identification of Deficient Practices/Corrective Action(s): All other residents receiving insuling the have been potentially affected. The EADON and/or designee will conduct 100% review of all resident's insuling orders to identify any residents at rising residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident for will be completed for each negative finding.	has on has on ot & ese nay ON, a All	

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

Event ID: 4K1G11

Facility ID: VA0109

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 281	hemiplegia, seizure dipsychotic disorder, chi disease, gastroesophi end stage renal disease. The most recent MDS an ARD (assessment coded the Resident a cognitive patterns. The (comprehensive care contained a plan for comprehensive contained approach (diagnosis): Diabete conder summary) dated part "TOUJEO SOLO 45ML SUBCUTANIOUDX (diagnoses) DM TGLARGINE, HUMAN The start date for this 08/29/16. The Resident's MAR's record) for the month December 2016 were entry which read in part 300 UNITS/ML GIVE QAM DX (diagnoses) month of October, the "N" on the following days: 11 November, the MAR the following days: 11 11/14, 11/16, 11/18-1	isorder, anxiety, depression, pronic obstructive pulmonary ageal reflux disease, and ise. 6 (minimum data set) with reference date) of 10/13/16 s 2 out of 15 in section C, ee Resident's CCP plan was reviewed and liabetes which read in part 14/16 Endocrine Dx s. Goal and target date: mal glocuse levels over the ches: insulin as ordered." record was reviewed on I a signed POS (physician's 12/13/16 which read in STAR 300 UNITS/ML GIVE JS QAM (every morning) YPE II Generic: INSULIN RECOMBINANT ALALOG".	F 2	81	Systemic Change(s): The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licens staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include giving at ordered time and physician notification a medication is held or refused. Monitoring: The DON is responsible for maintaining compliance. The DON and/or ADON was review medication orders weekly coinciding with the care plan calendar is order to maintain compliance. Any/all negative findings will be corrected at the of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: January 29, 2017	if g vill n me tl		

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

Event ID: 4K1G11

Facility ID: VA0109

If continuation sheet Page 4 of 47



PRINTED: 01/05/2017 FORM APPROVED OMB NO 0938-0391

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	12/05/12/06, 12/08-12 comments section of with "N" read in part " 300UNITS/ML GIVE 4was held.special red surveyor could not look hold the Toujeo insulin stating the physician is toujeo had been held. The surveyor spoke w #1 on 12/14/16 at app. Resident #3's insulin is "special requirement" Resident's daughter dinsulin given if Reside below a certain level. below what level did theld, and RN #1 answ thereabout". The surveyor spoke w nurse) #3, who is Resident's daughter dinsuling is required to the surveyor spoke w nurse) #3, who is Resident's tated "She bottomed just feel better about hasked LPN #3 if she had so the surveyor was the toujeo. Surveyor are selected better about hasked LPN #3 if she had so the surveyor was the toujeo.	d with "N" for 12/01-12/02, 2/09, 12/11, and 12/14. The the MAR on the days signed TOUJEO SOLOSTAR 45ML S scheduled for quirement not met". The cate any physician's order to nor any nurse's notes had been notified when the with RN (registered nurse) proximately 1615 regarding being held and what the was. RN #1 stated that the id not want the Toujeo nt's blood sugar levels are Surveyor asked RN #1 he daughter want the Toujeo rered "below 150, 170 or with LPN (licensed practical ident #3's daughter on stely 1030 regarding holding asked LPN #3 why she is insulin be held and she out on me one day and I olding it". Surveyor then	F:	281			
	The concern of holding physician's order was	discussed with the 12/14/16 at approximately quested the facility egarding insulin				-	

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Event ID: 4K1G11

Facility ID: VA0109

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F 281	Continued From page	5	F	281			
	The DON (director of surveyor with a copy of Medications" on 12/15 which read as follows:	of "Administering 5/16 at approximately 0800,					
	Policy Statement Medications shall be a timely manner, and as Policy Interpretation a 3. Medications must b accordance with the o required time frame.	nd Implementation e administered in					
	The surveyor was also "Adverse Consequence which read as follows:	provided with a copy of es and Medication Errors"		TO THE PARTY AND ADDRESS OF THE PARTY AND ADDR			
	Policy Interpretation and Implementation 5. A "medication error" is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing these services. 6. Examples of medication errors include: a. Omission-a drug is ordered but not administered.						
	insert information on To follows: Patient Information TOUJEO	vith a copy of the package					
	300 Units/ml (U-300) How should I use TOUง						

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Event ID: 4K1G11

Facility ID: VA0109

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F 281	tells you to. Your heal you how much TOUJI it. Know the amount of Tounge the amount of Tounge the amount or your healthcare provid TOUJEO should be upon the same time each of the same time each of the same time each of the DON stated to the she had spoken with 12/14/16 regarding the Toungeo insulin and procopy of a nurse's note "12/14/16 6:10pm Phote (name omitted) to clar that since Toungeo is a be given on a consister medication to do its jook Resident's fasting block 119, Dr gives verbal units QAM. Begin Toung 35 units subcutaneous sugar log for next 48 heresults. RP (responsibnotified." DON also procopy of the new physical	thcare provider should tell EO to use and when to use TOUJEO you use. Do not FTOUJEO you use unless der tells you to. sed 1 time each day and at ay. E surveyor on 12/15/16, that Resident #3's physician on e administration of the wided the surveyor with a which read in part one conversation with Dr rify Toujeo order. Dr stated long acting insulin, it must ent basis in order for the	F	281				
F 309 SS=E	483.25 PROVIDE CAF HIGHEST WELL BEIN Each resident must re	ceive and the facility must care and services to attain tracticable physical,	F3	1	F309 Corrective Action(s): Residents #2's attending physician was notified that the facility failed to administer the pain medication Norco and the antibiotic Bactrim as ordered by the attending physician. A facility Medication for the pain was completed for this			

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

accordance with the comprehensive assessment

Event ID: 4K1G11

Facility ID: VA0109

incident.

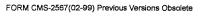
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If continuation sheet Page 7 of 47



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A BUILDING			E SURVEY PLETED
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PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI. TAG	×	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	and plan of care. This REQUIREMENT by: Based on staff interview, and clinical receivew, and clinical received practicable well-being Residents #2, #18, #3. The findings included. 1. For Resident #2, the administer the pain meantibiotic bactrim as or physician. The record review reveadmitted to the facility included, but were not syndrome, anemia, and dysphagia. Section C (cognitive paquarterly MDS (minimulation of the companion of the properties) some of points. Section J (healt indicate the Resident health of the problem) included the problem.	is not met as evidenced ew, facility document cord review, the facility staff ces for the highest for 6 of 20 Residents, , #12, #6, and #14. e facility staff failed to edication norco and the edered by the attending ealed that Resident #2 was 06/09/15. Diagnoses limited to, chronic pain xiety, osteoporosis, and etterns) of the Residents am data set) assessment ent reference date) of MS (brief interview for 13 out of a possible 15 th conditions) was coded to ad no pain in the last 5 e (comprehensive care lem area of pain. dminister medications as		309	Resident #18 is no longer in the facility. Resident #18's attending physician was notified that the facility staff failed to administer the antihypertensive medication Metoprolol as ordered by the physician while a resident in the facility. A facility Medication Error form was completed for this incident. Residents #3's attending physicians was notified that the facility failed to administer or follow the bowel protocol for resident #3 who did not have a bowe movement for 7 days in October, 5 day in November & 5 days in December as ordered by the physician. A facility Incident and Accident form was completed for this incident. Resident #12's attending physician was notified that the facility staff failed to administer PRN Zofran medication for nausea per physician order. A facility Medication Error form was completed f this incident. Residents #6's attending physicians was notified that the facility failed to discontinue a pain medication and start new pain medication per physician order A facility Medication Error form was completed for this incident. Residents #14's attending physician was notified that the facility staff failed to administer Florajen Bifidoblend as ordered by the physician. A facility Medication Error form was completed for this incident as ordered by the physician. A facility Medication Error form was completed for this incident.	e	



Event ID: 4K1G11

Facility ID: VA0109

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495320	B. WING_			12/	15/2016
	ROVIDER OR SUPPLIER				SS, CITY, STATE, ZIP CODE OD MAIN STREET, ROUTE 607 PO VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	The clinical record inc A physicians order da the physician to "Disc tabsStart Norco 7.5/BID (twice a day) pair Physician's progress that and dated 11/30/16 the increase Norco to 7.5 A review of Resident and medication administrated 2016 indicated that the administering Norco 76 hours not BID. The clinical record incetranscribed by LPN (linethat read "New MD order Lortab 5mg when exhalt Norco 7.5/325 mg one (responsible party) agresident and sign received and November 2016 we surveyor was unable to indicate the facility radministered any printed indicated the nursing in November 2016 and we documentation to indicate the cregarding the Norco doorders with the surveyor was unveyor was asked about the cregarding the Norco doorders with the surveyor with the surveyor was wasked about the cregarding the Norco doorders with the surveyor was unveyor was asked about the cregarding the Norco doorders with the surveyor was unveyor was asked about the cregarding the Norco doorders with the surveyor was unveyor was asked about the cregarding the Norco doorders with the surveyor was unveyor was unveyor was asked about the cregarding the Norco doorders with the surveyor was unveyor was unveyor was unveyor was unveyor was asked about the cregarding the Norco doorders with the surveyor was unveyor was unv	cluded the following. Ited 11/30/16 and signed by continue Norco 5mg (325 mg tab 1 po (by mouth) Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed by the physician at read in part "CPS-will mg po BID + follow" Iteranscribed	F3	Practices All other potential and Unit audit of a MAR's to Residente corrected comprehe reflect th attending each neg Incident complete Systemic The facilit been revi- warranted assessmen 24 Hour I medical re the source and monit which ince and comp medicatio include for administer order. The consultant nursing strobbaning, physician orders. As	ration of Deficient s/Corrective Action(s): residents may have been ly affected. The DON, ADON Managers will conduct a 100% all resident's physician orders to identify resident at risk. si identified at risk will be at time of discovery and their ensive plans of care updated to eir resident specific needs. The graphysicians will be notified of ative finding and a facility & Accident Form will be at for each negative finding. **Change(s): ity policy and procedures have ewed and no revisions are at this time. The nursing int process as evidenced by the Report and documentation in the ecord /physician orders remain the document for the developme toring of the provision of care cludes, obtaining, transcribing deting physician orders, on orders, treatment orders. To collowing the bowel protocol and ring medications per physician the DON and/or Regional nurse the will inservice all licensed aff on the procedure for transcribing, and completing medication and treatment to well as performing physician conitoring and follow up per orders.	he as nt	

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

Event ID: 4K1G11

Facility ID: VA0109

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JAN 12 2017

PRINTED: 01/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEPOCIENCES AND PLAN OF CORRECTION A 95320 A 95020 A 121 A 95320 A 121 A 953	CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	0. 0938-0391
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD ONLY PRICED ACACH REPRESENCE OF STREET FOR PERCEPTION RY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 9 #2 then called the contracting pharmacy in the presence of the surveyor. After this phone conversation LPM #2 verbalized to the surveyor that the harmacy stated they did not have a script for this order. On 12/13/16 at approximately 4:00 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that she was unable to locate an order to indicate the Resident was receiving 7.5/325 mg of norco. On 12/13/16 at approximately 4:12 p.m. LPM #2 approached the surveyor and stated she had spoken to the physician via phone and he had stated the order for the norce was supposed to be every 6 hours. A clarification order signed by the physician and dated 12/13/16 was provided to the surveyor that read "Received new order to DC Cipro. Start Bactrin DS PO BID X 7 days. RP (responsible party) and pharmacy notified." A review of the Resident #2's eMAR's for November 2016 indicated that the cipro had been discontinued on 11/07/16. However, the bectrim had not been stated until 10/03/16 and awa dosed everyday. This medication was available at the facility in the stat box for administration.								
HERITAGE HALL CLINTWOOD SUMMARY STATEMENT OF DEFICIENCES SUMMARY STATEMENT OF DEFICIENCY S			495320	B. WING_	~ ~~~~~~	(1900) distributiva establica de l'acquisite de production de montre di administrati de l'acquisite de l'acquis	12	/15/2016
(X4) ID SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 9 #2 then called the contracting pharmacy in the presence of the surveyor. After this phone conversation LPN 22 verbalized to the surveyor that the pharmacy stated they did not have a script for this order. On 12/13/16 at approximately 4:00 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that she was unable to locate an order to indicate the Resident was receiving 7.5/325 mg of norco. On 12/13/16 at approximately 4:12 p.m. LPN #2 approached the surveyor and stated she had stated the order for the norco was supposed to be every 6 hours. A clarification order signed by the physician and dated 12/13/16 was provided to the surveyor that read "Received new order to DC (Cipro, Later) B). The clinical record included a telephone order dated 11/07/16 and signed by the physician and attent of Cipro. Start Bactrin DS PO BID X 7 days. RP (responsible party) and pharmacy notified." A review of the Resident #2's eMAR's for November 2016 indicated that the cipro had been discontinued on 11/07/16. However, the bactrim had not been stated until 10/09/16 and was dosed everyday. This medication was available at the facility into stated that for each of the cipro had been discontinued on 11/07/16. However, the bactrim had not been stated until 10/09/16 and was dosed everyday. This medication was available at the facility into state took or administration.	NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
CLINWOOD, VA. 24228 CROSS REPERENCE OF THE PROPOSED BY FILL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	HERITAGI	E HALL CLINTWOOD			12	225 CLINTWOOD MAIN STREET, ROUTE 607 PO	BOX 909	
FREETX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 9 #2 then called the contracting pharmacy in the presence of the surveyor. After this phone conversation LPN #2 verhalized to the surveyor that the pharmacy stated they did not have a script for this order. On 12/13/16 at approximately 4:00 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that she was unable to locate an order to indicate the Resident was receiving 7.5/325 mg of norco. On 12/13/16 at approximately 4:12 p.m. LPN #2 approached the surveyor and stated she had spoken to the physician via phone and he had stated the order for the norco was supposed to be every 6 hours. A clarification. Norco 7.5 mg/325 i (one) po q 6 hrs scheduled Dx (diagnosis) Chronic Pain.'' B). The clinical record included a telephone order dated 11/07/16 and signed by the physician to "DXC (piro (antibiotic) 500 mg Begin Bactrim DS (double strength) PO QD (every day). X 7 days" and a nursing entry regarding the antibiotics that read "Received new order to DC CiproStart Bactrim DS PO BID X 7 days. RP (responsible party) and pharmacy notified." A review of the Resident #2's eMAR's for November 2016 indicated that the cipro had been discontinued on 11/07/16. However, the bactrim had not been started until 10/09/16 and was dosed everyday. This medication was available at the feelilip in the state box for administration.	TILITATAO	TIMEL CLINTWOOD			С	LINTWOOD, VA 24228		
#2 then called the contracting pharmacy in the presence of the surveyor. After this phone conversation LPN #2 verbalized to the surveyor that the pharmacy stated they did not have a script for this order. On 12/13/16 at approximately 4.00 p.m. the surveyor spoke with pharmacist #1 via phone. Pharmacist #1 verbalized to the surveyor that she was unable to locate an order to indicate the Resident was receiving 7.5/325 mg of norco. On 12/13/16 at approximately 4.12 p.m. LPN #2 approached the surveyor and stated she had spoken to the physician via phone and he had stated the order for the norco was supposed to be every 6 hours. A clarification order signed by the physician and dated 12/13/16 was provided to the surveyor that read "Clarification. Norco 7.5 mg/325 i (one) po q 6 hrs scheduled Dx (diagnosis) Chronic Pain." B). The clinical record included a telephone order dated 11/07/16 and signed by the physician to "D/C Cipro (antibiotic) 500 mg Begin Bactrim DS (double strength) PO QD (every day) X 7 days" and a nursing entry regarding the antibiotics that read "Received new order to DC CiproStart Bactrim DS PO BID X 7 days. RP (responsible party) and pharmacy notified." A review of the Resident #2's eMAR's for November 2016 indicated that the cipro had been discontinued on 11/07/16. However, the bactrim had not been started until 10/09/16 and was dosed everyday. This medication was available at the facility in the stat box for administration.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	((EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	BE .	COMPLETION
received a total of 12 doses. If the order had been	F 309	#2 then called the corpresence of the surve conversation LPN #2 that the pharmacy sta script for this order. On 12/13/16 at approximate approximate approached the surve spoken to the physicial stated the order for the every 6 hours. A clariff physician and dated 1 surveyor that read "Climg/325 i (one) po q 6 (diagnosis) Chronic Paraditated 11/07/16 and significant approached the surve spoken to the physicial stated the order for the every 6 hours. A clariff physician and dated 1 surveyor that read "Climg/325 i (one) po q 6 (diagnosis) Chronic Paraditated 11/07/16 and significant and a nursing entry reread "Received new of Bactrim DS PO BID X party) and pharmacy read the residual pharmacy read the residual pharmacy residual that the state of the facility in the state by the the bactrim was	ntracting pharmacy in the eyor. After this phone verbalized to the surveyor ted they did not have a eximately 4:00 p.m. the charmacist #1 via phone. Zed to the surveyor that she can order to indicate the eg 7.5/325 mg of norco. In the pharmacy of norco. In the p	F3	809	Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor compliance. Any/all negative findings or errors will be corrected at time of discovery and disciplinary action will taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarters for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: January 29, 2017	for and be f	

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Event ID: 4K1G11

Facility ID: VA0109

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PRINTED: 01/05/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495320	B. WING			12/15/2016	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZII 1225 CLINTWOOD MAIN STREET, CLINTWOOD, VA 24228			
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-	CTION SHOULD BE O THE APPROPRIA		
14 doses if the ord Resident should of Resident should of On 12/15/16 at ap surveyor spoke with Pharmacist #2 very pharmacy had del to the facility on 11 removed from the The DON (director of the conflicting in antibiotic on 12/15. The administrative and nurse consultar regarding the Resi antibiotic therapy of survey team on 12. No further informate provided to the surconference. 2. For Resident #1 administer the Resimetoprolol as orde was for twice a day the medication one. The record review if had been admitted Diagnoses included diabetes, hypertens chronic pain. Section C (cognitive	Resident should have received der had been everyday the nly have received 7 doses. proximately 11:08 a.m. the th pharmacist #2 via phone. balized to the surveyor that the vered 14 doses of the antibiotic /08/16 and 1 dose had been stat box. of nursing) was made aware formation regarding the /16 at approximately 11:20 a.m. team (administrator, DON, ant) was notified of the issues dents pain medication and juring a meeting with the /15/16 at 12:45 p.m. ion regarding this issue was vey team prior to the exit 3 the facility staff failed to idents hypertensive medication red by the physician. The order the facility had administered	F	309			

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Event ID: 4K1G11

Facility ID: VA0109

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JAN 12 207

PRINTED: 01/05/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE &	MEDICAID SEDVICES		OMB NO. 0938-0
CENTERS FOR MEDICARE &	WEDICAID SERVICES		T
TATELOG OF DEFICIENCIES	(X1) PROMINER/SLIPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY

	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	S manufactura and the second s	COMPLETED
		495320	B. WING		12/15/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 CLINTWOOD, VA 24228	PO BOX 909
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 309	11/21/16 included a mental status) sumpossible 15 points. This was a closed of the clinical record in Admission orders for "metopro Directions: 1 tablethypertension." Physician order sumpossible that incomposition or the sumposition of the contraction of the clinical medication administion and December 201 had been administed 8:00 a.m. throughout facility. The contracting phase in the contraction of the contracting phase in the contracting	ecord review. Included the following. Included the the property of the physician of the the order. Included the order. In	F 30		
	The DON (director	of nursing) was notified of the			

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Event ID: 4K1G11

Facility ID: VA0109

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	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
		495320	B. WING			12	/15/2016
	ROVIDER OR SUPPLIER HALL CLINTWOOD			122	REET ADDRESS, CITY, STATE, ZIP CODE 15 CLINTWOOD MAIN STREET, ROUTE 607 PO INTWOOD, VA 24228	BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 309	issue regarding the R medication on 12/15/a.m. The administrative teand nurse consultant regarding the Reside medication during a non 12/15/16 at 12:45 No further information provided to the surve conference. 3. For Resident #3 th facility bowel protocol Resident #3 was adm 06/14/06 and readmit included but not limite diabetes mellitus, hyp	lesidents blood pressure 16 at approximately 8:15 am (administrator, DON,) was notified of the issues nts blood pressure neeting with the survey team p.m. n regarding this issue was y team prior to the exit e facility staff failed to follow I.	F:	309	DEFICIENCY) .		
	psychotic disorder, cl disease, gastroesoph end stage renal disease. The most recent MDS an ARD (assessment coded the Resident a cognitive patterns. The (comprehensive care contained a plan for compart "Problem Onset: times. Goal and target bowel movements and over the next 90 days medications as order Resident #3's clinical	aronic obstructive pulmonary lageal reflux disease, and ase. S (minimum data set) with reference date) of 10/13/16 as 2 out of 15 in section C, he Resident's CCP plan was reviewed and constipation which read in 10/14/16 Constipation at let date:will have regular and no signs of constipation as Approaches: Administer					

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Facility ID: VA0109

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495320	B. WING_			12/15/2016
	ROVIDER OR SUPPLIER E HALL CLINTWOOD				SS, CITY, STATE, ZIP CODE OD MAIN STREET, ROUTE 607 PO VA 24228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
	that Resident #3 had 10/01-10/07/16, a tot 11/10-11/15/16, a tot 11/10-11/16, a tot 11/10-11/1	er, November and el movement roster indicated no bowel movements from al of 7 days, from al of 5 days and from a total of 5 days. ted and was provided a copy rotocol which read in part vel protocol will be initiated I Movement. The 'standing ocol will be as follows: 1. z every day PO (by mouth) ay 3 of no bowel movement opository 1 per rectum (PR) wel movement (BM). 3. ectum (PR) on day 5 of no nin 24 hours of initiation of ot locate any information vel protocol had been owel protocol not being ed with the administrative approximately 1630. It was provided prior to exit. The facility staff failed to eded) medication per mitted to the facility on included but not limited to	F3	09		

PRINTED: 01/05/2017 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495320	B. WING		-	12/15/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA 1225 CLINTWOOD MAIN ST CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)	
F 309	Continued From page	e 14	F3	309		
	depression, psychotic and gout.	disorder, hypothyroidism,				
	an ARD (assessment coded the Resident a cognitive status. This Resident #12's clinica 12/15/16. It contained order summary) which "ALLOPURINOL 100 mouth) daily, AMLOD TAB 1 po daily, PLAV LEXAPRO 10 MG TA MG TABLET 1 po dail po daily, PANTOPRAD 1 po daily, TORSEMII daily, LISINOPRIL 5 M (every day), KLOR-CC (twice daily), CALTRA ONE PO BID, FERROTABLET ONE PO BID	Il record was reviewed on la signed POS (physician's in read in part MG TABLET 1 po (by IPINE BESYLATE 5 MG IX 75 MG 1 po daily, BLET 1 po daily, ZETIA 10 y, LORATIADINE 10 MG 1 ZOLE SOD DR 40 MG TAB DE 20 MG TABLET ONE PO QD DN30 MEQ ONE PO BID ITE 600 + D TABLET GIVE DUS SULFATE 325 MG b, BUSPIRONE HCL 10 MG H OIL + D SOFTGEL ONE				
	record) for December contained the following 100 MG TABLET 1 po AMLODIPINE BESYL PLAVIX 75 MG 1 po dTABLET 1 po daily, ZE daily, LORATIADINE PANTOPRAZOLE SO daily, TORSEMIDE 20 LISINOPRIL 5 MG TA day), KLOR-CON30 M	ATE 5 MG TAB 1 po daily, aily, LEXAPRO 10 MG ETIA 10 MG TABLET 1 po 10 MG 1 po daily, D DR 40 MG TAB 1 po				

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Event ID: 4K1G11

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		495320	B. WING_			12	/15/2016
	PROVIDER OR SUPPLIER			1225	ET ADDRESS, CITY, STATE, ZIP CODE CLINTWOOD MAIN STREET, ROUTE 607 PO I ITWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	PO BID, FERROUS SONE PO BID, BUSPII PO BID, FISH OIL + II (three times daily)" T signed with "N" on 12 comments section of medication which read in part "ZO TABLET Q12 HOURS (diagnosis) NAUSEA/Resident's MAR also which had not been si administered. The surveyor spoke w nurse) #3 on 12/15/16 regarding holding Res Surveyor asked LPN # meds and LPN #3 statemeds were held because and was nauseated. She had administered and LPN #3 stated that she had not stated that she had not Surveyor informed the held and the prn not be meeting on 12/15/16 at approximal part "12/15/16 at approximal part "12/15/16 10:40 At to be in another Reside	SULFATE 325 MG TABLET IRONE HCL 10 MG TABLET D SOFTGEL ONE PO TID These entries had been 2/15/16, with notation in the the MAR for each d in part "held.nausea". also contained an entry DFRAN 4 MG TABLET ONE S AS NEEDED DX AND VOMITING". The contained the same entry, igned as having been with LPN (licensed practical s at approximately 1035 sident #12's medications. #3 why she had held the ted that Resident #12's use Resident had vomited Surveyor asked LPN #3 if Resident #12's prn Zofran at she had notified the ds had been held, and she of. DON of the meds being being administered during a at approximately 1245. Irse consultant) provided the	F3	309			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		DATE SURVEY COMPLETED
		495320	B. WING_			12/15/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE		
HERITAGI	E HALL CLINTWOOD			1225 CLINTWOOD MAIN STRE	ET, ROUTE 607 PO BOX 9	909
				CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCEI	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 309	Continued From page	· 16	F3	309		
	sick now'. Sitting up ir distress noted. Has w hallway. MD notified a	ates 'I feel better now I ain't n chair at this time. No heeled self through out at 1045. New order to give edications 15 minutes later.) aware"			·	
	No further information 5. For Resident #6 the discontinue an order forder. The clinical record of I 12/13/16 and 12/15/16 admitted to the facility included but not limite fibrillation, high blood gastroesophageal refluerthritis, bursitis, spon region, and anxiety. Resident #6's five day assessment with an as (ARD) of 5/8/15 asses cognitive summary of	provided prior to exit. e facility staff failed to or Norco and begin the new Resident #6 was reviewed 6. Resident #6 was 9/9/16 with diagnoses that d to Anemia, atrial pressure, heart failure, ux disease (GERD), dylosis of the cervical minimum data set (MDS) essessment reference date sed the resident to have a 8 out of 15. She was also and usually be understood. planned for pain and				
	spondylosis of the centre of n 12/14/16, Resident medication administrative reviewed. The surveyor resident was ordered mouth three times a damedication). With a distribution of nurses prescription for the Norpharmacy on 9/28/16.	wical region. It #6's September Ition record (MAR) was It observed that the Norco 10-325 tablet one by Italy (Norco is a pain Its continue date of 10/22/16. Its provided a copy of the Its cothat was faxed to the Its prescription read: It hree times a day) for pain."				

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Event ID: 4K1G11

Facility ID: VA0109

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STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		E SURVEY PLETED
	!	495320	B. WING			12	/15/2016
	ROVIDER OR SUPPLIER HALL CLINTWOOD			122	REET ADDRESS, CITY, STATE, ZIP CODE 15 CLINTWOOD MAIN STREET, ROUTE 607 PO INTWOOD, VA 24228	BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 309	two times a day (BID) was 9/28/16; however times a day was contion 10/14/16 at 10:00 Resident began to rectimes a day. On 12/15/16, at 2:30 consultant was shown The surveyor asked worder. He said "The cas ordered." On 12/15/16 prior to edirector of nurses and consultant were information related to the concern 6. For Resident #14 the follow physicians order Florajen Bifidoblend a Resident #14 was add 01/27/15 and was read Diagnoses included by COPD (chronic obstruction CVA (cerebrovascular hypertension, diabeted) The most recent MDS assessment complete significant change in SARD (assessment ref Section C (cognitive pass coded (1/1/3) indeproblems with short to and was severely implicated of Resident #14 was severely implicated of Resident #15 codes of Resident #16 codes of Resident #17 codes of Resident #17 codes of Resident #18 codes of Resident	d previously been ordered). The discontinue order date er the order for Norco two tinued until 10/14/16. Starting pm and on 10/15/16 the ceive the medication three pm the regional nurse n the order for the Norco. what happened with the order was not discontinued exit the administrator, d the regional nurse med of the medication error. In was provided by the facility in. the facility staff failed to er in the administration of a high potency probiotic. Imitted to the facility on admitted on 12/03/16. but were not limited to, suctive pulmonary disease), or accident/stroke), es, anxiety, and arthritis. S (minimum data set) ed on this Resident was a status assessment with an ference date) of 12/10/16. patterns) of this assessment dicating the resident had erm and long term memory paired in cognitive skills for d. #14's clinical record revealed		309			
	a physician's order fo						

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

Event ID: 4K1G11

Facility ID: VA0109

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CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY PLETED
		495320	B. WING		ell delano senso a molto qua por sono e me de mande e molto e molto a monte de molto e molto e molto e molto e	12	/15/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	. 10/2010
HERITAG	E HALL CLINTWOOD				1225 CLINTWOOD MAIN STREET, ROUTE 607 PO I CLINTWOOD, VA 24228	3OX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	capsule one po (by m days. The medication not started until 12/4/ was discontinued on received 6 days of the On 12/14/16 the direct medication error. After administration record of the medication had On 12/14/16 at 4:30 produced of the formed of the fradminister the medication administer the medication of the fradminister the medication.	outh) QD (every day) x 7 was ordered on 12/3/16 but 16. The Florajen Bifidoblend 12/9/16. Resident #14 only medication. tor of nurses was shown the r looking at the medication she agreed that all 7 days not been given as ordered. m, the administrator, regional nurse consultant ailure of the staff to		309			
SS=E	to the surveyor by the 483.25(I) DRUG REGI UNNECESSARY DRU Each resident's drug re unnecessary drugs. A drug when used in exc duplicate therapy); or f without adequate moni indications for its use; adverse consequences should be reduced or combinations of the resident, the facility mu who have not used ant given these drugs unless	facility staff. MEN IS FREE FROM IGS egimen must be free from n unnecessary drug is any essive dose (including or excessive duration; or toring; or without adequate or in the presence of s which indicate the dose discontinued; or any asons above. Insive assessment of a list ensure that residents ipsychotic drugs are not list and in the clinical	F 3.	29	F 329 Corrective Action(s): Resident #6's attending physician was notified that resident #6 was receiving both Omeprazole and Dexilant DR at the same time. Resident #6's attending physician reviewed resident #6's medication orders and discontinued the Dexilant DR order. A facility Incident & Accident form and a medication error form was completed for this incident.		

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OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
		495320	B. WING_			12/	15/2016
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 225 CLINTWOOD MAIN STREET, ROUTE 607 PO LINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	This REQUIREMENT by: Based on staff intervireview, the facility starresidents (Resident #4 unnecessary medication of the facility staff failed Resident #6 medication receive two proton put The clinical record of 12/13/16 and 12/15/16 admitted to the facility included but not limite fibrillation, high blood gastroesophageal reflarthritis and anxiety. Resident #6's five day assessment with an a (ARD) of 5/8/15 asses cognitive summary of	is not met as evidenced ew and clinical record ff failed to ensure 1 of 20 6) was free from an ion. to accurately reconcile ons to ensure he did not mp inhibitor medications. Resident #6 was reviewed 6. Resident #6 was 9/9/16 with diagnoses that d to Anemia, atrial pressure, heart failure, ux disease (GERD), minimum data set (MDS) ssessment reference date ssed the resident to have a 8 out of 15. She was also and usually be understood. t #6's December tion record (MAR) was		329	Identification of Deficient Practice(s) and Corrective Action(s): All other residents receiving medication may have been potentially affected. The DON, ADON and/or Pharmacy consulta will review the medication orders of all residents to ensure that no unnecessary medications or duplicate medication therapy has been ordered. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding. Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of all medications. This includes verifying and reconciling all admission/readmission orders to ensure unnecessary or duplicate medications are not being ordered or administered.	s unt	

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OMB	NO.	093	38-	03	91

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495320	B. WING_			12/	15/2016
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			12	TREET ADDRESS, CITY, STATE, ZIP CODE 225 CLINTWOOD MAIN STREET, ROUTE 607 PO B LINTWOOD, VA 24228	3OX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 329	pump inhibitor) by mo MAR was Omeprazole inhibitor) by mouth da physician orders reve orders for both medical further review of Res revealed documentati taking both of the profession of October 2016. Then of October 2016. Then of October 2016. Then of October 2016. Then of October 2016 are physician order summensure the Resident of pump inhibitors. Review of Resident #4 dated 10/31/16 reveal documented: "GERD Dexilant." Review of dated 11/30/16 related physician's document. Omeprazole, follow." I dated 12/13/16 by the follows: "GERD- Ome day)." On 12/14/16 the direct why resident #6 was of medications. She respat the record and see At 11:20am, the surve pharmacist by telephon Resident #6 should be pump inhibitor medical the Residents medications.	exilant DR 60 mg (proton buth daily. Also noted on the e DR 20mg (proton pump ily. Review of the December aled the Resident had ations. ident #6 clinical record on that Resident #6 was con pump inhibitor on the original pump inhibitor original pump inhib		329	Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or designee will complete weekly physicia orders and MAR audits coinciding with the Care plan calendar to monitor compliance. All negative findings will corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: January 29, 2017	n	

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Event ID: 4K1G11

Facility ID: VA0109

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CENTERS	FOR	MEDICARE .	& MEDICAID	SERVICES

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	NG	(**	COMPLETED		
		495320	B. WING_			12/15/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228		(909	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 329 F 333 SS=E	current order for the At 11:55am the direct surveyor she had consaid he thought the indexidence of the direct would call back. The with the physician withis did not occur. On 12/14/16 at 4:30 director of nurses and were informed of the team to reconcile the output of the survey team that the resident on the Ome Review of the facility Reconciliation of Me Read as follows und Medications, routes a accurately communications, routes a courately communication and care to procedures 5. Review determine if there are	s ordered, we don't have a Omeprazole DR 20mg. Stor of nurses informed the intacted the physician and he resident was only on the to review the record and surveyor asked to speak then he called back, however in the physician nurse consultant failure of the staff and care in Resident's medication. Stor of nurses informed the physician wanted the physician wanted the prazole. Policy and procedure titled dications on Admission for general guidelines: "4. In the physician wanted that and dosages have been cated to the attending from the list carefully to be discrepancies/conflicts." EXITS FREE OF	F3				
THE RESERVE OF THE PROPERTY OF	The facility must ens any significant medic	ure that residents are free of ation errors.					

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Event ID: 4K1G11

Facility ID: VA0109

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION ANIMOED.		2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495320	B. WING_	***********	aara kado di Montono mida bondo dhiin-abono uuda bada ka — Malka aara bi dhiiga — aa	12/	/15/2016	
	ROVIDER OR SUPPLIER HALL CLINTWOOD			122	REET ADDRESS, CITY, STATE, ZIP CODE 25 CLINTWOOD MAIN STREET, ROUTE 607 PO INTWOOD, VA 24228	BOX 909		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 333	by: Based on staff interv review, and clinical refailed to ensure 4 of 2 significant medication Residents #9, #14, #3 The findings included 1. For Resident #9, the 10 units of humalog in November and Decerphysicians order. The record review review and the included, but were noterm use of insulin, kindisease, and dementified with the included, but were noterm use of insulin, kindisease, and dementified with an ARD (assess 10/20/16 was coded and Resident had problem memory and was sev skills for daily decision. The Residents clinical physician signed (11/1/15 summary) that include "HUMALOGPER St. 0-150=0 UNITS, 151-UNITS, 251-300=6 UNITS, 2	is not met as evidenced iew, facility document food review, the facility staff to Residents were free of the errors involving insulin. The facility staff administered finsulin a total of 24 times in finber 2016 without a realed that Resident #9 had facility 04/22/16. Diagnoses to limited to, diabetes, long diney failure, chronic kidney a. realed that Resident #9 had facility 04/22/16 bases to limited to, diabetes, long diney failure, chronic kidney a. realed that Resident #9 had facility 04/22/16 bases to limited to, diabetes, long diney failure, chronic kidney a. realed that Resident #9 had facility 04/22/16 bases to limited to, diabetes, long diney failure, chronic kidney a. realed that Resident #9 had facility 04/22/16 bases to limited to, diabetes, long diney failure, chronic kidney a. realed that Resident #9 had facility 04/22/16 bases to limited to, diabetes, long diney failure, chronic kidney a. realed that Resident #9 had facility 04/22/16 bases to limited to, diabetes, long diney failure, chronic kidney a. realed that Resident #9 had facility 04/22/16 bases to limited to, diabetes, long diney failure, chronic kidney a.	F3	33	Corrective Action(s): Resident #9's attending physician has been notified that the facility failed to administer Humalog Sliding scale insulin per physician order. The nurse involved entering the initial one time insulin order incorrectly has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Medication error form was completed for each incident. Resident #14's attending physician has been notified that the facility failed to administer Lantus insulin per physician order. LPN #3 involved in holding the insulin incorrectly has received one-onone inservice training from the DON on the administration of physician ordered medications. A facility Medication error form was completed for each incident Resident #3's attending physician has been notified that the facility staff did no administer insulin per physician order an held resident #3's insulin without notifying the attending physician. Resident #3's physician order insulin has been reviewed to ensure all medication orders are accurate. A Facility Incident & Accident Form was completed for these incidents.	in r ot ad		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		
		495320	B. WING	B. WING		12/15/2016
	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1225 CLINTWOOD MAIN STREET, RO CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		
An a for hh T composite the second se	medication administrated December 2016 reported from December 10 units and administered 10 units and from December 10 units and no irregularities reported. After reviewing the climater of the consultant verbal and placed that there has and placed the order in and put the order in incomparation or administicological which is not hysician's orders" The administrative staff administrator in training ursing), and nurse consultant medication of Resident #9 during arm on 12/14/16 at appear on 12/14/16 at appear of the significant medication of the si	#9's eMAR's (electronic tion records) for November evealed that for the month ty nursing staff of humalog insulin 18 times -13 the facility nursing staff units of humalog insulin 6 hacist had completed a drug as Resident on 11/2_/2016 egarding the insulin were hical record the clinical edized to the surveyor that it ad been a one-time order at some point and whoever into the computer system correctly. Bedure titled "Adverse edication Errors" read in error" is defined as the tration of drugs or in accordance with the #9's eMAR's (electronic tion records) for the survey or in accordance with the survey oproximately 4:30 p.m. regarding this issue was		Resident #8's attending physician notified that the facility administer Novolin R Slidin insulin per physician order. did not administer the Novo per physician order has rece one inservice training from the administration of physician medications. A facility Med form was completed for each and Corrective Action(s): All other residents receiving ordered Insulin may have perfected. A 100% review of with insulin orders will be considered in the completed for each of discovery and appropriate action taken. An Incident and form will be completed for each of the facility policy and probeen reviewed and no chan warranted at this time. All will be inserviced on the facility physician orders to include administration of insulin to sliding scale insulin as order physician.	y failed to g scale The nurse the nurse the nurse the in R insuling ived one-one the DON or ian ordered ication error incident Practice(s) Physician ordered ication error incident Practice(s) Physician ordered to the incident ordered to the incident ordered to the incident ordered to the incident ordered at time and Accident each negative cedure has ges are Licensed streeting to the proper include	nn h- n- nn nr een tts n ne try ve

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Facility ID: VA0109

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	0. 0938-0391
	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495320	B. WING			12/	15/2016
NAME OF P	ROVIDER OR SUPPLIER		and the state of t	STREET ADDRESS, CITY, STATE, ZIP CODE			
LIEDITACI	LIEDITA OF HALL OF INTROOP			12	225 CLINTWOOD MAIN STREET, ROUTE 607 PO	3OX 909	
HERITAGE HALL CLINTWOOD			С	LINTWOOD, VA 24228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 333	ensure insulin was given physician to prevent a error. Resident #14 was add 01/27/15 and was read Diagnoses included be COPD (chronic obstructor) (cerebrovascular hypertension, diabeted) The most recent MDS assessment complete significant change in section C (cognitive personnel was coded (1/1/3) indeproblems with short to and was severely impedaily decision making	the facility staff failed to be a significant medication witted to the facility on different medication witted on 12/03/16. The facility on different medication were not limited to, active pulmonary disease), accident/stroke), accident/stroke), and arthritis. In (minimum data set) and on this resident was a status assessment with an erence date) of 12/10/16. The facility of this assessment icating the resident had arm and long term memory aired in cognitive skills for		333	Monitoring: The Director of Nursing is responsible for maintaining compliance. The DON and/designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: January 29, 2017	or	
	Lantus insulin 24 units documented as admir administration record 12/9/16, 12/10/16, 12/ 2016. The explanatio nurse's notes was "sp The surveyor could no	nistered on the medication (MAR) at 6:30 AM on 12/16,12/13/16, and 12/15 in for the omission in the ecial requirement not met." of find in the clinical record a or a special requirement or			就 責		
	administer the Lantus computer blocked me parameters. She was for the parameters she	was asked why she did not insulin; she said "the giving it because of the asked if there was an order e responded, "Some put in order. I did not call the					

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Event ID: 4K1G11

Facility ID: VA0109

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	IPLE CONSTRUCTION	(X3	(X3) DATE SURVEY COMPLETED		
		495320	B. WING_			12/15/2016	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 1225 CLINTWOOD MAIN STREET CLINTWOOD, VA 24228		C 909	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN ((EACH CORRECTIVE , CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 333	physician because of the director of nurs asked why the insular response was "there Lantus." The concern was reduring a summary reduring without a phelong-acting insulined Resident #3 was accompliated but not limited diabetes mellitus, hemiplegia, seizure psychotic disorder, disease, gastroeso end stage renal disureduring the most recent Millian ARD (assessme coded the Resident cognitive patterns. Resident #3's clinical 12/14/16. It contains order summary) da part "TOUJEO SOL 45ML SUBCUTANI DX (diagnoses) DN GLARGINE, HUMA	es was shown the MAR and lin was not given. Her e was no reason to hold the eported to administrative staff meeting on 12/15/16 at 12:45 on was provided prior to the 12/15/16. the facility held the insulin ysician's order. Toujeo is a used to treat diabetes. Imitted to the facility on nitted on 03/14/13. Diagnoses ited to anemia, hypertension, yperlipidemia, dementia, e disorder, anxiety, depression, chronic obstructive pulmonary phageal reflux disease, and	F3	333			

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F (JINI	Mr r	NO	V LL.
OMB	NO.	093	8-0	391

STATEMENT OF DEPLOSMORES (APPLIANCE) CORRECTION (APPLIANCE) NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD (APPLIANCE) (APP	CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO). 0938-0391	
MARE OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD OCA1.00 OCA1.00 PRETIX CASCINETED STATES. A SUMMARY STATISHENT OF DESCRIPCING STATES. A SUMMARY STATISHENT OF DESCRIPCING STATES. A SUMMARY STATISHENT OF DESCRIPCING STATES. THE SUBJECT OF THE SUPPLIES STATES. A SUMMARY STATISHENT OF DESCRIPCING STATES. THE SUBJECT OF THE SUPPLIES STATES. STATES. THE SUBJECT OF THE SUPPLIES SUPPLIES STATES. STATES STATES. ST	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ` '					
HERITAGE HALL CLINTWOOD A			495320	B. WING			12/	15/2016	
F 333 Continued From page 26 08/29/16. The Resident's MAR's (medication administration record) for the months of October, November and December 2016 were reviewed and contained an entry which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBGUTANIOUS OAM DX (diagnoses) DM TYPE II", For the month of October, the MAR had been signed with "N" on the following days: 11/04-11/08, 11/10-11/12, 11/14, 11/16, 11/14-11/19, 11/1-11/25, and 11/28-11/29. For the month of December the MAR had been signed with "N" on the following days: 11/04-11/12, 11/14, 11/16, 11/14-11/19, 11/1-11/25, and 11/28-11/29. For the month of December the MAR had been signed with "N" on the following days: 11/04-11/12, 11/14, 11/16, 11/14-11/19, 11/1-11/125, and 11/28-11/29. For the month of December the MAR had been signed with "N" for 12/01-12/02, 12/05-12/06, 12/08-12/09, 12/11, and 12/14. The comments section of the MAR on the days signed with "N" read in part "TOUJEO SOLOSTAR 300UNITS/ML GIVE 45ML S scheduled forwas held special requirement not met". The surveyor could not locate any physician's order to hold the Toujeo insulin or any nurse's notes stating the physician had been notified when the Toujeo had been held. The surveyor spoke with RN (registered nurse) #1 on 12/14/16 at approximately 1615 regarding Resident #3's insulin being held. RN #1 stated that the Resident's daughter did not want the Toujeo insulin give in Resident's blood sugar levels are below a certain level. Surveyor asked RN #1 below what level did the daughter want the Toujeo insulin give in Resident's blood sugar levels are below a certain level. Surveyor asked RN #1 below what level did the daughter want the Toujeo insulin give in Resident's daughter on 12/15/16 at approximately 1/030 regarding holding					1225 CLINTWOOD MAIN STREET, ROUTE 607 PC	BOX 909			
D8/29/16. The Resident's MAR's (medication administration record) for the months of October, November and December 2016 were reviewed and contained an entry which read in part "TOUJEO SOLOSTAR 300 UNITS/ML GIVE 45ML SUBCUTANIOUS OAM DX (diagnoses) DM TYPE II". For the month of October, the MAR had been signed with "N" on the following dates: 10/01-10/03, 10/05, 10/11, 10/15-10/16, 10/24, 10/28, and 10/31. For November, the MAR had been signed with "N" on the following days: 11/04-11/08, 11/10-11/12, 11/14, 11/16, 11/18-11/19, 11/21-11/25, and 11/28-11/29. For the month of December the MAR had been signed with "N" for 12/01-12/02, 12/05-12/06, 12/08-12/09, 12/11, and 12/14. The comments section of the MAR on the days signed with "N" read in part "TOUJEO SOLOSTAR 300UNITS/ML GIVE 45ML S scheduled forwas held special requirement not met." The surveyor could not locate any physician's order to hold the Toujeo insulin or any nurse's notes stating the physician had been notified when the Toujeo had been held. The surveyor spoke with RN (registered nurse) #t on 12/14/16 at approximately 1615 regarding Resident #3's insulin being held. RN #1 stated that the Resident's daughter did not want the Toujeo insulin given if Resident's blood sugar levels are below a certain level. Surveyor asked RN #1 below what level did the daughter want the Toujeo held, and RN #1 answered 150-170. The surveyor spoke with LPN (licensed practical nurse) #3, who is Resident #3's daughter on 12/15/16 at approximately 1030 regarding holding	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETION	
	F 333	O8/29/16. The Resident's MAR' record) for the month December 2016 were entry which read in pa 300 UNITS/ML GIVE QAM DX (diagnoses) month of October, the "N" on the following d 10/11, 10/15-10/16, 1 November, the MAR the following days: 11/14, 11/16, 11/18-1 11/28-11/29. For the MAR had been signe 12/05-12/06, 12/08-1 comments section of with "N" read in part " 300UNITS/ML GIVE was held special re surveyor could not low hold the Toujeo insuling stating the physician Toujeo had been held. The surveyor spoke with 10 miles are below a cere RN #1 below what levels	s (medication administration is of October, November and it reviewed and contained an eart "TOUJEO SOLOSTAR 45ML SUBCUTANIOUS IDM TYPE II". For the it MAR had been signed with lates: 10/01-10/03, 10/05, 0/24, 10/28, and 10/31. For had been signed with "N" on 1/04-11/08, 11/10-11/12, 1/19, 11/21-11/25, and month of December the id with "N" for 12/01-12/02, 2/09, 12/11, and 12/14. The the MAR on the days signed 1/TOUJEO SOLOSTAR 45ML S scheduled for quirement not met". The cate any physician's order to in or any nurse's notes had been notified when the state of the stat	F	333	3			

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Facility ID: VA0109

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PRINTED: 01/05/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING _ B. WING 495320 12/15/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 HERITAGE HALL CLINTWOOD CLINTWOOD, VA 24228 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 333 F 333 Continued From page 27 requested her mother's insulin be held and she stated "She bottomed out on me one day and I just feel better about holding it". Surveyor then asked LPN #3 if she had discussed this with Resident #3's physician, and she stated that she had not. The concern of holding the insulin was discussed with the administrative team on 12/14/16 at approximately 1630. The DON (director of nursing) provided the surveyor with a copy of "Administering Medications" policy on 12/15/16 at approximately 0800, which read as follows: Policy Statement Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation

3. Medications must be administered in accordance with the orders, including any required time frame.

The surveyor was also provided with a copy of "Adverse Consequences and Medication Errors" which read as follows:

Policy Interpretation and Implementation 5. A "medication error" is defined as the preparation of administration of drugs or biological which is not in accordance with physician's orders, manufacturer specification, or accepted professional standards and principles of the professional(s) providing these services.

- 6. Examples of medication errors include:
- a. Omission-a drug is ordered but not administered.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMF	SURVEY PLETED
		495320	B. WING	B. WING		12	15/2016
	ROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 225 CLINTWOOD MAIN STREET, ROUTE 607 PO :LINTWOOD, VA 24228	BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page No further information	e 28 n was provided prior to exit.	F	333			
	4. For Resident #8 th administer the insulin physician ordered par short-acting insulin us	Novolin R within the rameters. Novolin R is a					
	included but not limite heart failure, hyperter hyperlipidemia, cereb dementia, Parkinson's depression, psychotic	ted on 01/22/15. Diagnoses ed to anemia, congestive nsion, diabetes mellitus, rovascular accident, s disease, anxiety, c disorder, chronic y disease, chronic kidney					
	an ARD (assessment coded the Resident a	6 (minimum data set) with reference date) of 10/12/16 s 11 out of 15 in section C, is is a quarterly MDS.		TO A A A A A A A A A A A A A A A A A A A			
	12/14/16. It contained order summary) which 100 UNITS/ML VIAL INSULIN FSBS (finge	er stick blood sugar) AC D UNITS, 61-150=0 UNITS, 0=4 U, 251-300=6U,		ATTERNATION OF THE PROPERTY OF			
	record) for the month December were revie which read in part "No	(medication administration s of November and wed and contained an entry DVOLIN R 100 UNITS/ML CALE INSULIN FSBS (finger					

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Facility ID: VA0109

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AND CLAN OF COORTON IN INDEC		1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495320	B. WING	12/15/2	
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO CLINTWOOD, VA 24228	BOX 909
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 333	UNITS, 61-150=0 UN 201-250=4 U, 251-30 351-400=10U, 401-99 11/17/16 at 4:30pm, to "Novolink sched was held. special required Blood Glucose: 193." The concern of holding physician ordered paraduring meeting with the 12/15/16 at approximate special required paraduring meeting with the second	i (before meals) 0-60=0 ITS, 151-200=2 U, 0=6U, 301-350=8U, 99=12U NOTIFY MD". On the MAR had been signed which read in part uled for 11/17/16 4:30 PM uirement not met. Pre Admin ing the insulin outside of rameters was discussed the administrative staff on attely 1245.	F 333		
F 428 SS=E	483.60(c) DRUG RECIRREGULAR, ACT OF The drug regimen of creviewed at least once pharmacist. The pharmacist must the attending physician nursing, and these results of the second pharmacist. This REQUIREMENT by: Based on staff interview the facility staff	report any irregularities to an, and the director of ports must be acted upon. T is not met as evidenced feiled to identify and report es for 4 of 20 Residents,	F 428	Corrective Action(s): Resident #3 has been re-assessed by attending physician and the consulting pharmacist for the accurate dose and administration of Toujeo Solostar. Resident #3's physician ordered Tou Solostar has been clarified and the comprehensive care plans has been revised to reflect approaches and interventions to meet the resident's current needs. Resident #6 has been re-assessed by attending physician and the consulting pharmacist for the use of proton-puninhibitor. Resident #6's physician on have been clarified and the Dexilant has been discontinued and the Omeprazole order has been clarified the comprehensive care plans has been revised to reflect approaches and interventions to meet the resident's current needs.	ng ijeo the ng ip ders DR

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495320	B. WING		MAN - Administration - Front and control of the Con	12/	/15/2016
NAME OF PI	ROVIDER OR SUPPLIER	Name of the second seco	, and a second s	S	STREET ADDRESS, CITY, STATE, ZIP CODE		An third rich rest phonography and a second a
TITOITAGE	THE CHAINMOOD		,	17	225 CLINTWOOD MAIN STREET, ROUTE 607 PO	BOX 909	
HERIAGE	E HALL CLINTWOOD			C	CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 428	and report an error or summary) and MAR (record) for the dosage Toujeo. Resident #3 was adm 06/14/06 and readmitt included but not limite diabetes mellitus, hyphemiplegia, seizure dipsychotic disorder, chidisease, gastroesophend stage renal disea. The most recent MDS an ARD (assessment coded the Resident as cognitive patterns. Resident #3's clinical 12/14/16. It contained order summary) dated part "TOUJEO SOLOS 45ML SUBCUTANIOL DX (diagnoses) DM T GLARGINE, HUMAN The Resident's MAR's record) for the months December 2016 were entry which read in pa 300 UNITS/ML GIVE 4	facility staff failed to identify in the POS (physician's order (medication administration e of the long acting insulin, whitted to the facility on ted on 03/14/13. Diagnoses ed to anemia, hypertension, perlipidemia, dementia, lisorder, anxiety, depression, pronic obstructive pulmonary pageal reflux disease, and ase. S (minimum data set) with the reference date) of 10/13/16 is 2 out of 15 in section C, record was reviewed on the a signed POS (physician's decent and the 12/13/16 which read in 18/13/16 which read in 18/13/		428		n of as y	
	300 UNITS/ML GIVE (QAM DX (diagnoses)						

The surveyor spoke with pharmacist #3 on

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495320	B. WING		12/15/2016
	ROVIDER OR SUPPLIER E HALL CLINTWOOD		1	STREET ADDRESS, CITY, STATE, ZIP CODE 225 CLINTWOOD MAIN STREET, ROUTE 607 CLINTWOOD, VA 24228	' PO BOX 909
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERS) CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 428	12/14/16 at approxim pharmacist #3 what t insulin should be for stated the correct ord 300u/ml give 45 units. Resident #3's clinical "Medication Regimer months of April-Dece pharmacist had initial months and checked asterisk (*) was defin as "Based on the info of the review, and ascompleteness of sucl professional judgeme Resident's medication irregularities (as defin 483.60(c)). For purpostatement, the term " or circumstance that with customary, acce providing pharmaceu that could reasonably interfere with the ach reasonably expected. The concern of the diorder and MAR for To a meeting with admin approximately 1630. No further information 2. The consulting phareconcile Resident #6	he correct dosage of Toujeo Resident #3 and pharmacist for should read "Toujeo Be rather than 45ml. I record contained a Review" form for the Imber 2016. The consulting Ided and dated the form for all I the box labeled "NI*". The I red at the bottom of the form I remain available at the time I suming the accuracy and I information, it is my I intended in SOM Appendix PP I is ed in SOM Appendix PP I is ed in the foregoing I irregularity" means an event I is substantially inconsistent I pted clinical approaches to I tical product and services, or I be expected to impede or I ievement of intended or I outcomes." I is crepancy in the physician's I is cre	F 428	Systemic Change(s): The facility Policy and Procedure here reviewed and no changes are warranted at this time. The consultate pharmacist will review all resident's medication regime monthly to addrappropriate use, reduction, and elimination if needed. All licensed nursing staff will be inserviced by the DON on the importance of monitor medication regimens for medication reduction and elimination as recommended by the Consulting Pharmacist. The DON and/or ADC review all pharmacy recommendation monthly to ensure that any/all pharmacy recommendations have been address and proper notification to attending physicians has been completed. Monitoring: The DON is responsible for maintait compliance. The DON, and/or designing will perform monthly audits of the pharmacy recommendations are being commendations are being commended in followed up on timely. Any/all negative findings will be corrected a of discovery. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: January 29, 2017	ant s sess he ing n on one of the ing n on one of the ing n one of the ing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		G	X3) DATE SURVEY COMPLETED	
		495320	B. WING			12/15/2016	
	ROVIDER OR SUPPLIER		a a a a a a a a a a a a a a a a a a a	STREET ADDRESS, CITY, STATE, ZIP C 1225 CLINTWOOD MAIN STREET, RG CLINTWOOD, VA 24228		607 PO BOX 909	
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F 428	12/13/16 and 12/15/r admitted to the facilit included but not limit fibrillation, high blood gastroesophageal re arthritis and anxiety. Resident #6's five da assessment with an (ARD) of 5/8/15 asse cognitive summary o coded to understand On 12/14/16, Reside medication administr reviewed. The survey resident was taking I pump inhibitor) by m MAR was Omeprazo inhibitor) by mouth d physician orders reve for both medications. Further review of Re- revealed documenta- taking both of the pro medications in the m of October 2016. The pharmacist, nurses of reconciled the POS a Resident did not rece inhibitors. The pharmacy medic was documented for 2016. The pharmacis that the review was of	Resident #6 was reviewed 16. Resident #6 was y 9/9/16 with diagnoses that ed to Anemia, atrial di pressure, heart failure, flux disease (GERD), y minimum data set (MDS) assessment reference date essed the resident to have a f 8 out of 15. She was also and usually be understood. Int #6's December ation record (MAR) was yor observed that the Dexilant DR 60 mg (proton bouth daily. Also noted on the le DR 20mg (proton pump aily. Review of the December ealed the resident had orders sident #6 clinical record tion that Resident #6 was often pump inhibitor onths of November and part ere was no evidence that the ir the physician had and the MAR to ensure the	F	428			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION 4G	(X3) DATE SURVEY COMPLETED		
		495320	B. WNG _		1	2/15/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIE	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 428	hospital. The clinical documentation that reported the irregular and the irregular and the irregular and the Resident #6 should pump inhibitor medithe Residents med Resident #6 was donly the Dexilant was current order for the At 11:55am the director of the irregular and wanted would call back. The physician where did not occur. On 12/14/16 at 4:3 director of nurses a were informed of the irregular that the irregular information is survey team that the irregular information is survey to the irregular information in its survey in i	er that the Resident was in the all record did not reveal any tindicated the pharmacist had larity to the physician. Inveyor contacted the phone and asked him if the beauting of the stated, when dications. After he reviewed dication list he stated, when discharged from the hospital was ordered, we don't have a decomparable DR 20mg. The contacted the physician and he decontacted the physician and he decontacted the physician and he decontacted the record and the surveyor asks to speak with the he called back, however this the failure of the staff and care the Resident's medication. The physician wanted the meprazole only. The to exit no further information	F	128		
	The record review	revealed that Resident #9 had				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495320	B. WING			12	/15/2016
	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE 25 CLINTWOOD MAIN STREET, ROUTE 607 PO LINTWOOD, VA 24228		10,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 428	Continued From page 34 been admitted to the facility 04/22/16. Diagnoses included, but were not limited to, diabetes, long term use of insulin, kidney failure, chronic kidney disease, and dementia.		F	428			
	quarterly MDS (mining with an ARD (assess 10/20/16 was coded Resident had probler	ns with long and short term verely impaired in cognitive		16.—MALIEMBERHARDER A.A. D. MERCH 4744 ARRESTANDA ARIA ARIA ARIA ARIA ARIA ARIA ARIA AR			
	summary) that includ "HUMALOGPER S 0-150=0 UNITS, 151 UNITS, 251-300=6 U	103/16) POS (physician order ed an order for LIDING SCALE COVERAGE -200=2 UNITS, 201-250=4 INITS, 301-350=8 UNITS." inistered daily before meals					
	medication administr completed for Novem This review revealed November the facility 10 units of humalog i December 1-13 the f	ber and December 2016.					
	regimen review for the and no irregularities reported. In fact the pure corresponding box "Non the bottom of the	macist had completed a drug is Resident on 11/2_/2016 regarding the insulin were charmacist had checked the NI*." Per the preprinted code form titled "MEDICATION NI was defined as "Based					

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(DESTREMANDED)		1	MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495320	B. WING_			2/15/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 1225 CLINTWOOD MAIN STREET, ROU CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 428	review, and assuming completeness of such professional judgement Resident's medication irregularities (as defir 483.60(c)). For purpostatement, the term or circumstance that with customary, acceproviding pharmaceut that could reasonably interfere with the ach reasonably expected. After reviewing the claurse consultant vertappeared that there is for 10 units of insulin had placed the order had put the order in it. The facility policy/proconsequences and Mart-"A "medication preparation or admin biological which is not physician's orders" The administrative st (director of nursing), notified of the above team on 12/15/16 at. No further information provided to the surve conference.	railable at the time of the g the accuracy and h information, it is my ent that at such time, the n regimen contained no new ned in SOM Appendix PP use of the foregoing irregularity" means an event is substantially inconsistent epted clinical approaches to tical product and services, or a be expected to impede or inverse interest of intended or outcomes." Initial record the clinical policied to the surveyor that it had been a one-time order at some point and whoever into the computer system incorrectly. Incedure titled "Adverse Medication Errors" read in a error" is defined as the istration of drugs or out in accordance with the	F	128		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495320	B. WING	er him Ahmer van de kanada sakk me din oor van de klasse aan aan de oorween sakke van de sakke sakke sakke sak		12/15/2016
	ROVIDER OR SUPPLIER HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 428	failed to identify and record the Resident's blood process. The record review revented been admitted to Diagnoses included, but diabetes, hypertension chronic pain. Section C (cognitive process admission MDS (minimized minimized minimi	eport irregularities regarding pressure medication to the sealed that Resident #18 the facility 11/14/16. But were not limited to, in, depression, anxiety, and seatterns) of the Residents mum data set) assessment ment reference date) of IMS (brief interview for any score of 15 out of a luded the following. In the hospital that included tartrate 25 mg tablet all twice a day for many signed by the physician ded the order TRATE 25 MG TAB 1 in) BID (twice a day) DX extension)." Tents eMAR's (electronic tion records) for November evealed that this medication doinly one time a day at the Residents stay at the macist had completed a drug Residents medications in	F	428		
The state of the s		The surveyor was unable				

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Facility ID: VA0109

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		495320	B. WING		12	/15/2016
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 P CLINTWOOD, VA 24228	D BOX 909	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		BE	(X5) COMPLETION DATE
1	pharmacist had acted medication error. The the corresponding box REGIMEN REVIEW' for any noted irregular recommendations." H report was not shared A random review of the pressures was comple problems being identify. The Resident was discuted to the problems being identify. The DON (director of a problems being identify. The DON (director of a problems being identify. The administrative tea and nurse consultant) regarding the Resident medication during a mon 12/15/16 at 12:45 p. No further information provided to the survey conference. 483.65 INFECTION COSPREAD, LINENS The facility must established for the survey conference.	on or was aware of the pharmacist had checked on the "MEDICATION form that read "See report rities and/or owever, a copy of this for provided to the surveyor. The Residents blood eted by the surveyor with no fied. Charged from the facility on the esidents blood pressure 6 at approximately 8:15 Im (administrator, DON, was notified of the issues the blood pressure eeting with the survey team of the common. The regarding this issue was team prior to the exit the exit the exit the exit the exit that and maintain an intermined the environment and exelopment and transmission.		Corrective Action(s): LPN #2 involved in the Medication Pa for Resident #1 has been inserviced or on-one on proper hand washing and infection control practices during medication administration pass. A Fac Incident & Accident form was comple	e- lity	
				for this incident.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495320	B. WING	Secret Vision du augusticos de la constitución de l	12/15/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
UEDITAC	E HALL CLINITWOOD			1225 CLINTWOOD MAIN STREET, ROUTE 607 PO	BOX 909
HERITAG	E HALL CLINTWOOD			CLINTWOOD, VA 24228	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 441	Program under which (1) Investigates, contri in the facility; (2) Decides what prod should be applied to a (3) Maintains a record actions related to infe (b) Preventing Spread (1) When the Infection determines that a resi prevent the spread of isolate the resident. (2) The facility must p communicable diseas from direct contact will tran (3) The facility must re hands after each direct hand washing is indice professional practice. (c) Linens Personnel must hand transport linens so as infection. This REQUIREMENT by: Based on staff intervi review, and during a r observation the facility	Program blish an Infection Control it - rols, and prevents infections redures, such as isolation, an individual resident; and d of incidents and corrective ctions. If of Infection in Control Program ident needs isolation to infection, the facility must rohibit employees with a se or infected skin lesions th residents or their food, if smit the disease. require staff to wash their ct resident contact for which atted by accepted If a store, process and to prevent the spread of is not met as evidenced we, facility document medication pass and pour y staff failed to follow control guidelines in regards	F 44	Identification of Deficient Practice(s) & Corrective Action(s): All residents may have the potential to be affected by improper hand washing and infection control techniques. The DON and/or ADON will conduct medication pass audits on all licensed staff to observe proper infection control practices and proper hand washing during medication administration procedures. Any negative findings will be addressed immediately and disciplinary action taken as needed a facility Incident and Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed staff will be inserviced on the facility policy and procedure for proper hand washing and the infection control policy and procedure by the DON and/or Regional Nurse Consultant. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or designee will perform 2 random weekly Medication Pass audits to monitor nursin staff for compliance. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: January 29, 2017	e A

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CENTERS FOR IMEDICARE & MEDICAID SERVICES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		495320	B. WING			12/15/2016	
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228		(909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	hygiene during a medobservation. On 12/14/16 beginning a.m. the surveyor observations on the right medications on the right medications to unsan returned to the medications for the number of the removed her gloves, she had administered medications for the number of t	aff failed to complete hand dication pass and pour and at approximately 7:55 served LPN (licensed repare and administer ght side. After administering appled Resident #1 LPN #2 sation cart in the hallway, signed for the medications of the dications of the dications of the serveral minutes the #2 about washing her hands ygiene after removing her alized to the surveyor that ther hands but she would aff (administrator, DON AIT (administrator in consultant) were notified that plete hand hygiene after during a meeting with the 4/16 at approximately 4:50 p.m. the the designated infection	F 44				

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Event ID: 4K1G11

Facility ID: VA0109

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OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495320	B. WING	****	40 Meter engi chiqida filika malama sarahan sarahida kankusan sarahan sarahida kankusan sarahida kankusan sarah	12/	15/2016
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 441 F 502 SS=D	facility considers hand means to prevent the an alcohol-based han 62% alcohol; or, alternor non-antimicrobial) a situations After remois the final step after repersonal protective ed. No further information provided to the survey conference. 483.75(j)(1) ADMINIS The facility must proviservices to meet the none formation provided to the survey conference.	dedure titled Industrial description of the primary spread of infectionsUse of the containing at least matively soap (antimicrobial and water for the following ving glovesHand hygiene emoving and disposing of quipment." Tregarding this issue was a team prior to the exit		502	F502 Corrective Action(s): Resident #8's attending physician has been notified that the facility failed to obtain a Chem 13 lab test as ordered the physician. A Facility Incident & Accident form has been completed for	oy	
	by: Based on staff intervier review the facility staff ordered lab for 1 of 20 The findings included: For Resident #8 the fathe physician ordered months of August and Resident #8 was admit 12/27/16 and readmitted	failed to obtain a physician Residents, Resident #8. cility staff failed to obtain lab, Chem 13 level for the October 2016. tted to the facility on ed on 01/22/15. Diagnoses it to anemia, congestive			the missing labs. Identification of Deficient Practice(& 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 identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians who be notified of the missing labs, labs no obtained timely and labs obtained without a physician order. A facility Incident & Accident Form will be completed.	s)	

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CENTERS FOR MED	ICARE &	MEDICAID SERVICES				D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY PLETED
		495320	B. WING	Marini in process alama mahabu ara shirikana kandakina adililikan (1000-1000-1000-1000-1000-1000-1000-100	12	/15/2016
NAME OF PROVIDER OR SU	PPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	1225 CLINTWOOD MAIN STREET, ROUTE 607 P	O BOX 909	
HERITAGE HALL CLINT	WOOD			CLINTWOOD, VA 24228		
PREFIX (EACH	DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
dementia, F depression, obstructive disease, co The most re an ARD (as coded the F cognitive pa Resident #8 12/14/16. It order summ LEVEL Q (e The survey Chem 13 le October 20 (director of missing lab The concer during a me 12/15/16 at No further i 483.75(i)(1) RECORDS LE The facility resident in standards a	mia, cerebication of the meeting with approximation of the meeting with a proximation of the meeting with a	rovascular accident, so disease, anxiety, co disorder, chronic y disease, chronic kidney and dysphagia. So (minimum data set) with reference date) of 10/12/16 so 11 out of 15 in section Could be a signed POS (physician's the read in part "CHEM 13 NTH". The color of August 2016 and provided the could not. It is sing labs was discussed to the administrative team on	F 50	The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed a implemented to track and validate the required lab work has been complete 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 maintain compliance. The DON and/or design will complete the Facility Lab audit tweekly to monitor for compliance. A negative findings will be reported to attending physician and disciplinary action will be taken as warranted. The results of these audits will be reported the Quality Assurance Committee for review, analysis, & recommendation change in facility policy, procedure, and/or practice. Completion Date: January 29, 2017	y and at d	

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systematically organized.

The clinical record must contain sufficient

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Facility ID: VA0109

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	495320 B. WING			12/	15/2016		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 514	information to identify resident's assessment services provided; the preadmission screeni and progress notes. This REQUIREMENT by: Based on staff intervireview, the facility stacomplete and accurat 20 Resident's (Resided The findings included 1. The facility staff fail documentation to indiclarified a laboratory to panel) Resident #5's. Resident #5 was admand readmitted on 8/2 included but not limited pressure, heart failure esophageal reflux disconthe most recent mian assessment referent the facility staff assessunderstand and to be assessed to have a continuous continuous accordance on the most recent mian assessment referent the facility staff assessunderstand and to be assessed to have a continuous c	the resident; a record of the tts; the plan of care and e results of any ng conducted by the State; I is not met as evidenced liew and clinical record ff failed to ensure a se clinical record for 3 out of ents # 5, # 3 and # 7). I ded to maintain accurate cate that facility staff sest BMP (basic metabolic litted to the facility 11/18/05 e4/16 with diagnoses that add to dementia, high blood e, seizure disorder, and order. #5's clinical record revealed inimum data set (MDS) with ence date (ARD) of 11/29/16, sed the Resident to understood. She was ognitive summary score of of Resident #5's clinical record also revealed comprehensive metabolic		514	Corrective Action(s): Resident #5's attending physician has been notified that the facility staff faile to ensure that physician ordered BMP laboratory results were in the clinical record. A facility incident and accident form has been completed for this incident. Resident #3's attending physician has been notified that the facility staff faile to transcribe a physician ordered insuli order accurately. A facility incident and accident form has been completed for transcribe and accident form has been notified that the facility staff faile to accurately document antibiotic administration on the MAR. A facility incident and accident form has been completed for this incident. Identification of Deficient Practices and Corrective Action(s): All other residents may have potentiall been affected. A 100% audit of all resident medical records will be conducted by the DON, ADON and/or Medical Records clerk to identify residents at risk for an inaccurate medical record and illegible documentation. All negative findings will be clarified and/orrected at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negatifinding.	ent. d n d his d	
	by: Based on staff intervireview, the facility sta complete and accurat 20 Resident's (Reside The findings included 1. The facility staff fail documentation to indi clarified a laboratory t panel) Resident #5's. Resident #5 was adm and readmitted on 8/2 included but not limite pressure, heart failure esophageal reflux dis- A review of Resident on the most recent mi an assessment refere the facility staff asses understand and to be assessed to have a co 15. On 12/13/16 a review record revealed a phy 3 days, dated 11/15/1 an order for a CMP (co	iew and clinical record If failed to ensure a e clinical record for 3 out of ents # 5, # 3 and # 7). Ited to maintain accurate cate that facility staff est BMP (basic metabolic Indicated to the facility 11/18/05 E4/16 with diagnoses that ad to dementia, high blood a, seizure disorder, and order. If it is clinical record revealed inimum data set (MDS) with ance date (ARD) of 11/29/16, sed the Resident to understood. She was ognitive summary score of of Resident #5's clinical resician's order for a BMP in 6. The record also revealed comprehensive metabolic late of 11/15/16. The BMP			been notified that the facility staff faile to transcribe a physician ordered insuli order accurately. A facility incident an accident form has been completed for tincident. Resident #7's attending physician has been notified that the facility staff faile to accurately document antibiotic administration on the MAR. A facility incident and accident form has been completed for this incident. Identification of Deficient Practices Corrective Action(s): All other residents may have potentiall been affected. A 100% audit of all resident medical records will be conducted by the DON, ADON and/or Medical Records clerk to identify residents at risk for an inaccurate medirecord and illegible documentation. All negative findings will be clarified and/corrected at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negative	n d his d	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
		495320	B. WING			12/	15/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUT CLINTWOOD, VA 24228				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 514	The clinical record al obtained on 11/16/16 test found in the clinic On 11/13/16 LPN #4 order was received order day the lab was she had written the order want to stick Resider the CMP. The BMP is On 11/14/16 at 4:30 preeting the surveyor and director of nurse order for the BMP. Prior to exit no furthe surveyor. 2. For Resident #3 the ensure an accurate F summary) and MAR record). Resident #3 was adn 06/14/06 and readmincluded but not limit diabetes mellitus, hyphemiplegia, seizure opsychotic disorder, clisease, gastroesophend stage renal diseated. The most recent MDS an ARD (assessment)	so revealed that a CMP was it however there was no BMP cal record. told the surveyor that the in the 14th and counting the sidue on the 16th. She said order date incorrectly. ctor of nurse said, "We didn't at #5 twice so we obtained is part of the CMP." om during an end of the day informed the administrator is of the failure to clarify the informed the administrator is of the failure to clarify the interest was provided to the possible failed to not administration interest on 03/14/13. Diagnoses and to anemia, hypertension, perlipidemia, dementia, disorder, anxiety, depression, pronic obstructive pulmonary nageal reflux disease, and	F	514	Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff and Medical Records clerk will be inserviced by the DON or region 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 in the appropriate medical record and maintaining legible physician orders according to the acceptable professional standards and practices. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or designee will audit medical records, MAR's, TAR's, ADL records and care plans weekly coinciding with the care plan calendar to monitor for compliance Any/all negative findings will be clarifi 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: January 29, 2017	aal a	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED					
495320		B. WING		12/15/2016						
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD			122	STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)						
F 514	12/14/16. It contained order summary) dated part "TOUJEO SOLO 45ML SUBCUTANION DX (diagnoses) DM TGLARGINE, HUMAN The Resident's MAR's record) for the month December 2016 were entry which read in pa 300 UNITS/ML GIVE QAM DX (diagnoses) Surveyor spoke with at approximately 1115 Toujeo order. Pharma read 45 units, rather to the surveyor request physician's order for (director of nursing). Id ated 08/29/16, on 12/13/00. The order read units/ml Give 45 units QAM (every morning). Surveyor spoke with 12/14/16 at approxim Resident #3's Toujeo much Toujeo she adn that she did not know given it. Surveyor the and asked her to read	record was reviewed on I a signed POS (physician's d 12/13/16 which read in STAR 300 UNITS/ML GIVE US QAM (every morning) TYPE II Generic: INSULIN RECOMBINANT ALALOG". Is (medication administration of October, November and ereviewed and contained an eart "TOUJEO SOLOSTAR 45ML SUBCUTANIOUS DM TYPE II". In the properties of the order should than 45ml. In the provided the order, 2/14/16 at approximately in part "Toujeo Solostar 300 of Sub Q (subcutaneously)". RN (registered nurse) #1 on	F 514							

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	C	(X3) DATE SURVEY COMPLETED		
495320		B. WING	B. WING		12/15/2016			
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228				
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	S PLAN OF CORRECTION (AS COMPLE EXCEPTION SHOULD BE EXCEPT TO THE APPROPRIATE DEFICIENCY)			
F 514	14 Continued From page 45		F 5	14				
	discussed with the ac	correct POS and MAR were Iministrative staff during a at approximately 1630.						
	No further information was provided prior to exit. 3. For Resident #7, the facility staff failed to accurately document how many doses of the antibiotic bactrim had been administered. The record review revealed that Resident #7 had been admitted to the facility 11/11/14. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, muscle weakness, and hypertension. Section C (cognitive patterns) of the Resident's annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/30/16 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points.							
		d 12/01/16 for "Bactrim DS ne) BID (twice a day) X 7						
	medication administra the facility nursing sta had administered this	ents eMAR (electronic ation record) indicated that aff had documented that they medication from 12/01/16 09/16 at 8:00 p.m. for a total						
	surveyor spoke with p Pharmacist #1 verbal doses of bactrim had 12/01/16. When aske	ximately 3:30 p.m. the oharmacist #1 via phone. ized to the surveyor that 14 been sent to the facility on d if anything had been taken		Carlife ID VA0400	K again.	tion sheet Page 46 of 47		
FORM CMS-256	37(02-99) Previous Versions Obs	olete Event ID: 4K1G1	ł	Facility ID: VA0109	n condinua	uon sheeti aye 40 014/		

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938							0. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED	
		495320	B. WING			12/	15/2016
NAME OF PE	ROVIDER OR SUPPLIER			i .	REET ADDRESS, CITY, STATE, ZIP CODE	2 DOV 000	
HERITAGE	HALL CLINTWOOD			i	25 CLINTWOOD MAIN STREET, ROUTE 607 P INTWOOD, VA 24228	J BOX 909	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE
F 514	pharmacist #1 stated yet for this Resident is being pulled from the The administrative st (administrator in train nursing), and nurse of the incorrect docume antibiotic bactrim and meeting with the sun approximately 4:30 p	ne facility for this Resident she had nothing billed as of regarding this medication stat box for administration. aff (administrator, AIT ing), DON (director of consultant) were notified of notation regarding the I Resident #7 during a vey team on 12/14/16 at	F	514			

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