Our Home, Our Family, Our Life, Too.

Heritage Hall of Grundy • 2966 Slate Creek Road • Grundy, VA 24614 • (P) 276.935.8144

January 29, 2016

Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233

Mr. Miller;

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

Heritage Hall – Grundy is committed to providing high quality patient care. We appreciate your assistant in this matter.

If I can be of further assistance don't hesitate to contact me at (276) 935-8144.

Sincerely;

Derrick Ratliff Administrator RECEIVED

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January 29, 2016

Office of Licensure and Certification Division of Long Term Care Services 9960 Mayland Drive – Suite 401 Attn: Rodney Miller, Long Term Care Supervisor Richmond, VA 23233

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Sincerely;

Derrick Ratliff Administrator

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	{ · · ·	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	495259	B. WING		01/13/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP COI 2966 SLATE CREEK ROAD GRUNDY, VA 24614	
PRÉFIX : (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 000 INITIAL COMMENT	rs	F 00	00	
survey was conduct 01/13/16. Correction compliance with 42 Term Care requirem survey/report will for The census in this 1 112 at the time of the consisted of 20 curr (Residents #1 throut reviews (Residents F 226 483.13(c) DEVELOR SS=D ABUSE/NEGLECT, The facility must developolicies and procedures mistreatment, negle	CFR Part 483 Federal Long nents. The Life Safety Code llow. 20 certified bed facility was e survey. The survey sample ent Resident reviews gh #20) and 6 closed record #21 through #26). P/IMPLMENT ETC POLICIES velop and implement written	F 22	F226 Corrective Action(s): The RN and the LPN identemployee file review have license verified with the DHealth Professions and the was placed in her employee Incident & Accident form completed for this incident Identification of Deficien	had her LPN epartment of e printed copy ee file. A facility has been t.
This REQUIREMENT is not met as evidenced by: Based on staff interview, facility policy review and employee record review it was determined the facility staff failed to implement the facility abuse policy to screen and verify licensure records for 2 of 20 newly hired employees. Findings: Facility staff failed to screen/verify 2 new hires for licensure requirements per facility policy. The facility abuse prohibition policy contained the following requirement for new employee screening: "Careful screening of all employees,		ATI IDE	Corrective Action(s): All other licensed employed potentially affected. The B Manager and/or designed wo of all active licensed employed identify employees at risk. negative findings will be contime of discovery. A Facil Accident form will be commany/all negative findings. Systemic Change(s): The facility policy and procedure warranted at this time. Hum Staff will be inserviced and of the policy & procedure be Administrator on requiremed licensed staff prior to employ license or certification renewal.	usiness Office will audit 100% oyee records to Any/all orrected at the ity Incident & pleted for cedure has ges are an Resources issued a copy by the onts for all oyment and wal.
1/2/	THE THE STORY	NI OINE	TITLE	(X6) DATE

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

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STATEM	ENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	***************************************			<u> OMR M</u>	<u>0. 0938-039</u>
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI		CONSTRUCTION		ATE SURVEY DMPLETED
		495259	B. WING	i	gamer on all the residence is a sea on a period of the contraction of		1/42/2040
NAME (OF PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		1/13/2016
HERIT	AGE HALL GRUNDY			296	6 SLATE CREEK ROAD UNDY, VA 24614		
(X4) IE PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL GC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D RE	(X5) COMPLETION DATE
F 309	for all new employed On 1/13/16 at 12:30 reviewed 20 staff reviewe	tracted ense verification performed es prior to employment" PM the survey team cords for employees hired of The surveyors found two red nurse and one licensed did not contain verification of licenses prior to the e was hired on 6/22/15 and on was obtained on 1/11/16. all nurse was hired on ense was verified on 1/11/16. all nurse was hired on	F 30	226	Monitoring: The Humans Resources manager responsible for maintaining comp. The Human Resources Manager a designee will conduct monthly at employee files to maintain compl. The administrator will review all and report aggregate findings to the Quality Assurance Committee for analysis, and recommendations for changes in policy, procedure, and facility practice. Completion Date: 2-19-16 F309 Corrective Action(s): Resident #2's attending physician notified that the facility failed to a Bactroban to nares per physician facility Incident and Accident for completed for this incident. Resident #20's attending physician	oliance. and/or adits of iance. audits he review, or /or a was apply order. A m was	
	by:	is not met as evidenced			notified that the facility staff failed administer Albuterol/Atrovent net treatments per physician order. A Incident and Accident form was completed for this incident.	ulizer	

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

Event ID: 2CU411

Facility ID: VA0102

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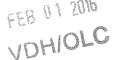
	NT OF DEFICIENCIES	TWILL SERVICES	7	****		OMB NO	D. 0938-03
AND PLA	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495259	B. WING)			* * * * * * * * * * * * * * * * * * * *
	F PROVIDER OR SUPPLIER AGE HALL GRUNDY				STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD		1/13/2016
-					GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	MILDRE	(X5) COMPLETIO DATE
F 309	follow physician ord survey sample, (Res 1. Facility staff failed Bactroban* administration for Res 3. Failed to follow or administration re: block Resident #1. Findings: 1. Facility staff failed Bactroban administration recate 8:30 AM. Resident #2 was administrates at 8:30 AM. Resident #2 was administrates at 8:30 AM. Resident #2 was administrates at 8:30 AM.	nined the facility staff failed to ers for 3 of 26 residents in the sidents #2, 20, and 1). It to follow physician orders for tration for Resident #2. Iders for Albuterol/Atrovent** esident #20. Iders for medication pod pressure parameters for ation for Resident #2. The ford was reviewed on 1/12/16 Initiated on 8/15/18. The cluded MRSA (methicillin s), congestive heart failure, abetes. Initiated on 8/15/18 assessment, id the resident was coded as assistance for all the ADLS	F3	333	Residents #1's attending physical notified that the facility failed Bumex per physician ordered for administration. A facility Accident form was completed incident. Identification of Deficient Practices/Corrective Actions All other residents may have to potentially affected. The DOI and Unit Managers will conduct audit of all resident's physicial MAR's to identify resident at Residents identified at risk will corrected at time of discovery comprehensive plans of care unreflect their resident specific nutending physicians will be not each negative finding and a fact Incident & Accident Form will completed for each negative finding and a fact Incident & Accident Form will completed for each negative finding assessment in the medical rephysician orders remains the solution of the development amonitoring of the provision of concludes, obtaining, transcribing includes, obtaining, transcribing incidents.	sicians were to hold parameters Incident and I for this I be and their pdated to eeds. The otified of bility be anding. The bear the point of the point of the I for the I fo	1
:	The current CCP (conupdated on 12/16/15 of infection or isolation pwas past tense.	nprehensive care plan) did not contain the MRSA recautions as the problem			completing physician medicatio & treatment orders. The DON a Regional nurse consultant will i all licensed staff on the procedu obtaining, transcribing, and comphysician ordered medication artreatment orders.	nd/or nservice re for pleting	
	The current physician' on 11/19/15, contained	s orders, signed and dated d an order for "Bactroban		:	:	1	

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

Event ID: 2CU411

Facility ID: VA0102

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495259	B. WING	was promotion and a field opposit and for the days and appeal and a first hand had promote the first opposit and about the first hand and promotion of the first hand and a first hand a fi			
	PROVIDER OR SUPPLIER GE HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP 2966 SLATE CREEK ROAD GRUNDY, VA 24614	CODE 01	/13/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	times a day) x five of 11/11/15 to treat MF nose. The TAR (treatment November 2015 were The Bactroban was through 11/20/15. The encompassed ten do ordered by the physical content of the surveyor input to the computer was an oversight on entering the order.	to each nostril TID (three days." The order was given on RSA colonized in the resident's administration records) for re reviewed for administration. provided from 11/11/15 his administration ays rather than the five days ician. AM the DON (director of	F 3	Monitoring: The DON will be respond maintaining compliance. ADON and/or Unit Mana audit/review all MAR's was monitor for compliance. Ifindings and or errors will time of discovery and diswill be taken as needed. Ifindings of these audits we the Quality Assurance Conquarterly for review, analy recommendations for charpolicy, procedure, and/or Completion Date: 2-19-1	The DON, agers will weekly to Any/all negative II be corrected at aciplinary action Aggregate vill be reported to sommittee ysis, and nge in facility practice.		
	impetigo as well as o by bacteria. This info the website:	tibiotic, is used to treat ther skin infections caused ormation was obtained from gov/medlineplus/druginfo/me					
	Albuterol/Atrovent** n physician's order. The was reviewed on 1/13 The resident was adm						
	obstructive pulmonary	/ disorder.)					

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2CU411

Facility ID: VA0102

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

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES					RM APPROVEI 10. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) E	DATE SURVEY COMPLETED
		495259	B. WING				01/13/2016
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		71/13/2010
HERITAG	GE HALL GRUNDY				966 SLATE CREEK ROAD RUNDY, VA 24614		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 4	F 3	09		-	
	admission MDS (m or CCP (compreher resident. His physic place as the admiss The physician's adm 1/7/16) signed and a "Ipratropium (Atrove micrograms inhaler times a day.)" The aforementioned the physician and a	d not yet completed the inimum data set) assessment asive care plan) on this ian admission orders were in sion care plan. nission orders (implemented dated 1/12/16 contained: ent)-Albuterol 18-103 give one inhalation QID (four d order was discontinued by telephone order was provided M: "Start Albuterol 0.083%					
	give 1 UD (unit dose (every) 6 hoursCO (Atrovent) BA 0.02% hoursCOPD"	e) via neb (nebulizer) Q DPDStart Ipratropium o (one) via neb Q 6					
	order from the physi "(arrow down sign	provided) a second telephone cian contained the following: indicating "reduce") QIDAtrovent with mask"					
; ;	administration record admission date until Albuterol/Atrovent inl	ed the MAR (medication d) for January 2016 from the 1/13/16. On 1/8/16 the haler was administered at 9 I 9 PM per the physician's					
•	The following was ob	oserved on the MAR: ovent administrations via					

5 PM, 6 PM, 9 PM.

1/10/16 - Albuterol/Atrovent Neb (nebulizer) treatments at 12 AM, 6 AM, 9 AM, 12 PM, 1 PM,



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				FOR	RM APPROVED 10. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B. WING	- Samuelous			1/13/2016
NAME OF	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		1713/2010
HERITA	GE HALL GRUNDY				966 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
;	1/11/16 - Albuterol//AM, 6 AM, 9 AM, 12 On 1/13/16 at 10:00 asked why the resid treatments every thr rather than every six DON informed the stwo telephone order neglected to delete computer after received on 1/13/16 at 11:30 assistant director of surveyor with a new physician. The ADOI physician and had the nursing staff." The newas for Albuterol/Atrobe provided four time Documentation reviet frame yielded no negthe resident due to the No additional info was survey team exit. *** Albuterol/Atrovent: albuterol and ipratrop wheezing, difficulty be and coughing in peopoulmonary disease (Chat affect the lungs at the side of the side of the lungs at the l	Atrovent neb treatments at 12 PM. AM the facility DON was ent was getting nebulizer see hours/ 8 times a day, a hours (QID) as ordered. The urveyor the staff had gotten is from the physician and had the first one from the ving the second order. AM the ADON (facility nursing) provided the telephone order from the N stated, "I called the lee order clarified for the lew order from the physician ovent nebulizer treatments to less a day (or every six hours.) I weed during the critical time gative outcome apparent to the additional administrations. Is provided prior to the	F3	309			
t	o the lungs) and emp	physema (damage to the air					

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sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms

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Facility ID: VA0102

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					KM APPROVEI O. 0938-039
STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495259	B. WING			,	1/13/2016
NAME OF	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		1/13/2016
HERITA	GE HALL GRUNDY				SLATE CREEK ROAD INDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	have not been contributed and ipratro class of medications. Albuteroclass of medications. Albuteroclass of medications. Albuterol and ipratro relaxing and openin lungs to make breat was obtained from the https://www.nlm.nih.ds/a601063.html 3. Failed to follow or administration re: blook Resident #1. Resident #1 was readified to the facility had the following dia ascites* (abnormal by abdomen), osteomy of stage IV pressure Hepatitis C** (an infl. Hepatitis C, is cause (HCV)), encephalopaterm for any diffuse of alters brain function of dysfunction of bladdefailure. Resident #1's MDS (lassessment protocol Reference Date) of 1 with a BIMS (Brief Int score of 15 out of 15, cognitively intact. Reas needing extensive members for bathing	rolled by a single inhaled of and ipratropium are in a scalled bronchodilators. Spium combination works by g the air passages to the thing easier. This information he website: gov/medlineplus/druginfo/me rders for medication pood pressure parameters for admitted to the facility on resident was originally the ty on 2/20/15. Resident #1 gnoses of, but not limited to: buildup of fluid in the gelitis** (infection of the bone) ulcer***, diabetes, chronic ammation of the liver. It is dependently in a disease of the brain that for structure), neuromuscular for, heart failure and kidney Minimum Data Set, an or with an ARD (Assessment /13/16 coded Resident #1 terview for Mental Status), indicating the resident was esident #1 was also coded assistance by 2 staff	F 3)9			

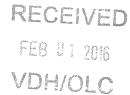
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for Resident #1, it was noted that the following order was on the MAR (Medication Administration

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Facility ID: VA0102

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CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES					O. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) D	(X3) DATE SURVEY COMPLETED	
		495259	B. WING		0	1/13/2016	
	PROVIDER OR SUPPLIER BE HALL GRUNDY	A A Company of the Co		STREET ADDRESS, CITY, STATE, 2966 SLATE CREEK ROAD GRUNDY, VA 24614		1710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
	Continued From page 7 Record) for January, 2016: "Bumex ***^1 mg (milligram) Tablet Take 1 Tab (tablet) PO (by mouth) BID (twice a day) Hold if SBP (Systolic Blood Pressure) < (less than)100". On 1/11/16 at 9 am, the nurse documented on the MAR that the resident had a BP of "92/60" and that the dose of Bumex was administered to Resident #1. ***^Bumex (Bumetanide) is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Other uses for this medicine: Bumetanide is also sometimes used to treat high blood pressure. IMPORTANT WARNING: Bumetanide is a strong diuretic ('water pill') and may cause dehydration and electrolyte imbalance. It is important that you take it exactly as told by your doctor.			09			
	On 1/12/16 at 4:30 p.m. in the ADON (assistant director of nursing) office, the ADON was notified of and interviewed regarding the above documented findings on Resident #1's MAR for January, 2016. The ADON stated "They should have held that dose of medicine". On 1/12/16 at 5 p.m. in the conference room, the administrator, director of nursing, ADON and corporate nurse were notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 1/13/16.						
•		as obtained from the website: .nih.gov/pubmedhealth/PMH					

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website:

** This information was obtained from the

Event ID: 2CU411

Facility ID: VA0102

ontinuation sheet Page 8 of 32



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	2	
HERITAC	GE HALL GRUNDY			2966 SLATE CREEK ROAD GRUNDY, VA 24614		
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F 309	Continued From pa	ge 8	F 3	09		
	https://www.nlm.nih.gov/medlineplus/ency/article/000437.htm					
	and/or underlying tisprominence, as a rein combination with Category/Stage IV: Full thickness tissue tendon or muscle. Spresent. Often inclutunneling. The deptil pressure ulcer varie bridge of the nose, enot have (adipose) sthese ulcers can be ulcers can extend in structures (e.g., fasc making osteomyeliti Exposed bone/musc palpable. This inform website: <http: td="" www.npuap.com<=""><td>is localized injury to the skin asue usually over a bony esult of pressure, or pressure shear. Full thickness tissue loss loss with exposed bone, slough or eschar may be des undermining and n of a Category/Stage IV is by anatomical location. The ear, occiput and malleolus do subcutaneous tissue and shallow. Category/Stage IV ito muscle and/or supporting cia, tendon or joint capsule) is or osteitis likely to occur. Cle is visible or directly mation was obtained from the org/resources/educational-and puap-pressure-ulcer-stagesc</td><td></td><td></td><td></td><td></td></http:>	is localized injury to the skin asue usually over a bony esult of pressure, or pressure shear. Full thickness tissue loss loss with exposed bone, slough or eschar may be des undermining and n of a Category/Stage IV is by anatomical location. The ear, occiput and malleolus do subcutaneous tissue and shallow. Category/Stage IV ito muscle and/or supporting cia, tendon or joint capsule) is or osteitis likely to occur. Cle is visible or directly mation was obtained from the org/resources/educational-and puap-pressure-ulcer-stagesc				
, ,	website:	vas obtained from the n.gov/medlineplus/hepatitisc.h				
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	***^ This information	was obtained from the				

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https://www.nlm.nih.gov/medlineplus/druginfo/m

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Facility ID: VA0102

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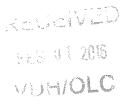
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		495259	B. WING			
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	01/13/2016	
LEDITA	GE HALL GRUNDY			2966 SLATE CREEK ROAD		
HEKHA	SE HALL GRUND!			GRUNDY, VA 24614		
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	eds/a684051.html>			F425		
F 425	483.60(a),(b) PHAF	RMACEUTICAL SVC -	F 42			
SS=D	ACCURATE PROC	EDURES, RPH		Resident #11's attending physician	was	
				notified that the resident was not		
	The facility must pro	ovide routine and emergency		administered the Cefepime antibior	tic per	
		ls to its residents, or obtain		physician order. A Facility Inciden		
	them under an agre			Accident Report has been complete	ed for	
	9483.75(n) of this p	art. The facility may permit		this incident.	:	
	law permits, but only	el to administer drugs if State		Resident #18's expired antibiotics	were	
	law permits, but only under the general supervision of a licensed nurse.			removed from the medication room	l	
	oupor violott of a fice	rised ridise.		refrigeration and destroyed.		
	A facility must provid	de pharmaceutical services		**		
		es that assure the accurate		Identification of Deficient Practic	es &	
•	acquiring, receiving,			Corrective Action(s): All other residents may have been	1	
	administering of all	drugs and biologicals) to meet		potentially affected. The DON, AE	ION	
	the needs of each re	esident.		and/or designee will conduct a 1009		
				review of all current resident medic	ations	
	The facility must em	ploy or obtain the services of		in the medication carts for availabil		
	a licensed pharmaci	st who provides consultation		well as all medication rooms to incl		
	services in the facilit	provision of pharmacy		medication refrigerators to identify	any	
	services in the facilit	у.		unavailable or expired medications. Any/all negative findings will be		
				corrected at time of discovery. A F	acility	
				Incident & Accident Report will be	activity	
				completed for each incident identific	ed.	
	This REQUIREMEN	T is not met as evidenced				
	by:			Systemic Change(s):		
;		view, facility document		The facility policy and procedure ha	ıS	
		d review and staff interview, it		been reviewed and no changes are warranted at this time. The licensed	:	
		the facility staff failed to		nursing staff will be inserviced by the	10	
	ensure IV (intraveno	us) antibiotic medication was		pharmacy consultant and/or DON or		
		le for administration for 1 of		policy for monitoring resident	;	
	26 residents in the si	urvey sample, (Resident #1);		medications to include, proper labeli	ing,	
		of expired medications for 1		dating and availability. As well as th	ie	
:	of 26 Residents, Res	ident#10.		removal of all expired medications to		
	1 Escility staff failed	to ensure Resident #1's		include all medications and biologic	al	
	domity stair railed	to chadre (veside) if #13		from the medication rooms and medication carts.		
				medication carts.		

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Event ID: 2CU411

Facility ID: VA0102

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
٠		495259	B. WING				4143/2040
	PROVIDER OR SUPPLIER GE HALL GRUNDY			296	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614	<u> </u>	1/13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	;	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(X5) COMPLETION DATE
	medication was obta administration on 1/at 9:00 a.m. 2. The facility staff 18's expired medication C wing included vancomycin (antibio labeled as belonging expiration date of 12. The findings include 1. 1. Facility staff fair physician ordered IV medication was obta administration on 1/s at 9:00 a.m. Resident #1 was real 1/9/16 however, the admitted to the facility had the following dia ascites* (abnormal baddomen), osteomycof stage IV pressure Hepatitis C*^ (Hepatitiver. One type, hepatitiver. One	/ (intravenous) antibiotic ained an available for 9/16 at 9:00 p.m., and 1/10/16 failed to dispose of Resident # tion. The medication room expired IV (intravenous) tic). This medication was g to Resident #18 and had an t/02/15. It ded to ensure Resident #1's / (intravenous) antibiotic ained an available for 19/16 at 9:00 p.m., and 1/10/16 of the ditter was originally by on 2/20/15. Resident #1 gnoses of, but not limited to: wildup of fluid in the elitis** (infection of the bone) ulcer***, diabetes, chronic tits is an inflammation of the titts C, is caused by the V)), encephalopathy*** Interm for any diffuse disease is brain function or structure), inction of bladder, heart	F 4	25	Monitoring: The DON is responsible for maintain compliance. The DON, and/or desig will perform weekly medication Car Medication Room audits to monitor compliance. Detail findings of this a will be reported to the Quality Assur Committee for review, analysis, and recommendations for change in facil policy, procedure, and/or practice. Completion Date: 2-19-16	nee t & for udit rance	

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Event ID: 2CU411

Facility ID: VA0102

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DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 01/21/2016

CENTERS FOR MEDICARE & MEDICAID SERVICES						M APPROVED 0. 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DA	ATE SURVEY OMPLETED
		495259	B. WING		0.	1/13/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		1/13/2010
HERITA	GE HALL GRUNDY			2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	members for bathin During the review o on 1/12/16, it was d (Medication Adminis January, 2016 under Cefepime (antibiotic staff to administer a p.m. dose. Resider from the hospital on facility on this date a arrived to the facility order: "Cefepime 2 via (by) IV (intravence (diagnosis): Wound a discharge diagnosis hospital. On 1/10/10 documented on the for the medication o "unavailable from phe (medical doctor) not find a physician order record. At 4:35 p.m., the assand 1/10/16. The assand 1/10/16. The assand 1/10/16. The assand 1/10/16 assand it was pharmacy and it was That is what the nurs on 1/10 at 9 a.m., the medicine was unavailable manay and MD mo one has charted the surveyor asked	g and dressing. f Resident #1's clinical record ocumented on the MAR stration Record) dated or details that the medication retently was "Unavailable" for its ordered on 1/9/16 for the 9 at #1 had been discharged in 1/9/16 and arrived at the at 8 p.m. The resident had with the following physician gram Solution Take 12 gram ous) Q (every) 12 hrs. Dx Infection". Resident #1 had sis of Osteomyelitis from the 6 at 9 a.m., it was detail of the resident's MAR of Cefepime that this drug was narmacy, pharmacy and md iffied". The surveyor did not the for this date on the clinical sistant director of nursing was ident #1's MAR for 1/9/16 as unavailable from the as unavailable from the as unavailable from the as unavailable from the as to start in the am (morning), see has written in here. Then are nurse has written that the illable from pharmacy, otified. Then 1/10 at 9 p.m. that the medicine was given". the assistant director of sing staff was to do for a	F 4	25		

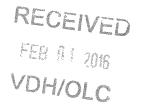


pharmacy. The assistant director of nursing stated, "Call the pharmacy, then get the medicine



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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495259	B. WING	NACASIONALIA (LANCASIA)	5000-billedrick (1800-billedrick (1800-b	0	1/13/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP COL		1713/2010
HERITAC	GE HALL GRUNDY				S SLATE CREEK ROAD JNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 425	Continued From particle from the back up plus be given".	ge 12 narmacy, so the medicine can	F 4	25			
	administrator, direct director of nursing a informed of the aborsurveyor asked what event that a medicatime it was to be give stated, "In the event happen, the staff is	i. in the conference room, the tor of nursing, assistant and the corporate nurse were we documented findings. The at the staff was to do in the tion was not available at the ten. The corporate nurse is like this, what should to call the pharmacy, notify rite an order as to what the lo in this case".					
	gave the surveyor a Medication Shortage Under the "Applicab documented, "This F procedures relating unavailable medicati "Procedure" section was documented in 3. "If a medic after normal Pharma 3.1 A licensed F the ordered medicati Medication Supply. 3.2 If the ordere in the Emergency Me Facility nurse should answering service ar registered pharmacis of action. Action mag	to medication shortages and ions". Under the of the policy the following part: ation shortage is discovered acy hours: facility nurse should obtain ion from the Emergency and medication is not available edication Supply, the licensed call Pharmacy's emergency and request to speak with the st on duty to manage the plan					

Third Party Pharmacy.

4. If an emergency delivery is unavailable,



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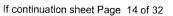
CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 09				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
		495259	B. WING		MARIJANI (SIMUMINING) OSANI (SIMUMINING) (SIMUMINING) SIMUMINING S	01/13/2	2016
	PROVIDER OR SUPPLIER BE HALL GRUNDY			296	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) MPLETION DATE
	physician to obtain a 8. When a miss Facility nurse should and the explanation MARand in the not Such documentation information: 8.1 A description medication shortage 8.2 A description upon notification; ar 8.3 Action(s) ta No further information work type of the surveyor prior to the References: * This information work type of the surveyor prior to the surveyor prior to the surveyor prior to the References: * This information work type of the surveyor prior to the surveyo	d contact the attending orders or directions sed dose is unavoidable, d document the missed dose for such missed dose on the urse's notes per Facility policy. In should include the following on of the circumstances of the experience of the experience on 1/13/16. On was provided to the exit conference on 1/13/16. As obtained from the website: In.nih.gov/pubmedhealth/PMH Invas obtained from the website: In.nih.gov/medlineplus/ency/article is localized injury to the skin sue usually over a bony sult of pressure, or pressure shear. Full thickness tissue loss loss with exposed bone, lough or eschar may be	F	.25			

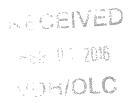


bridge of the nose, ear, occiput and malleolus do not have (adipose) subcutaneous tissue and









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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	strycester-motorio-reness-managers		OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495259	B. WING	0^0_00000 00^00000000000000000000000000	01/13/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAC	SE HALL GRUNDY			2966 SLATE CREEK ROAD GRUNDY, VA 24614	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC	ULD BE COMPLETION
F 425	Continued From pa	ge 14 shallow. Category/Stage IV	F 4	25	
	ulcers can extend into muscle and/or supporting structures (e.g., fascia, tendon or joint capsule) making osteomyelitis or osteitis likely to occur.				
Exposed bone/muscle is visible or directly palpable. This information was obtained from website: http://www.npuap.org/resources/educatio		mation was obtained from the			
		npuap-pressure-ulcer-stagesc			
	website:	was obtained from the h.gov/medlineplus/hepatitisc.h			
	website:	was obtained from the ih.gov/disorders/encephalopat			
	works by killing bact obtained from the w	cephalosporin antibiotics. It reria. This information was ebsite:			
	https://www.nlm.nih. ds/a698021.html	gov/medlineplus/druginfo/me			
	medication. The moincluded expired IV (antibiotic). This med	ailed to dispose of an expired edication room on C wing (intravenous) vancomycin dication was labeled as and had an expiration			
	Resident #18 was ad	dmitted to the facility on			



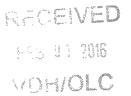


01/14/15. Diagnoses included, but were not

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D/	ATE SURVEY DMPLETED
		495259	B. WING		- NII dan hillidid dirina aan da aan aa kan aa aan aa aa aa aa aa ah aa ay	0	1/13/2016
	PROVIDER OR SUPPLIER SE HALL GRUNDY			296	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614	unamental anno anno process	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	Section C (cognitive 18's quarterly MDS assessment with an date) of 12/21/15 co. 15 out of a possible interview for mental resident was cognition. The Residents clinic (physician order sur documented the order PHARMACY." The complete of t	sion, anxiety, diabetes, chronic depression. Pe patterns) of the Resident (minimum data set) ARD (assessment reference oded the resident as scoring 15 points on the BIMS (brief status), indicating the vely intact. Cal record included a POS mmary) that included and ler "VANCOMYCIN PER date on this order was all record also included a ated 11/14/15 to "START M (gram) IV (intravenous) "The vancomycin had been 08/15. Coximately 10:55 a.m. the icensed practical nurse) #1 ion room on the C wing. The 3 bags of IV vancomycin. All mycin were labeled with e and had an expiration date Resident #18 was no longer mycin and she would dispose ion (director of nursing), and ector of nursing) were notified	F 4	.25			
		ation in a meeting with the 2/16 at approximately 5:05					

p.m.



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495259	B. WING	militari, additional and an additional and additional additional and additional and additional additio	01/13/2016
	PROVIDER OR SUPPLIER GE HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP 2966 SLATE CREEK ROAD GRUNDY, VA 24614	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BE COMPLETION BE APPROPRIATE DATE
F 425	provided the survey policy/procedure titl Expired or Discontine effective date of 12/read in part "Once medication is receiv remove this medication supply discontinued or out-designated, secure discontinued medications are destruction"	roximately 2:30 p.m. the DON for with a copy of the facility ed "Disposal/Destruction of foued Medications" with an 101/07. This policy/procedure e an order to discontinue a red, Facility staff should tion from the resident's Facility should place all dated medications in a location which is solely for eations or marked to identify discontinued and subject to on regarding the expired	F 4		
	prior to the exit conf 483.65 INFECTION SPREAD, LINENS The facility must est Infection Control Pro safe, sanitary and co to help prevent the co of disease and infect (a) Infection Control The facility must est Program under whice (1) Investigates, con in the facility; (2) Decides what pro should be applied to	ablish and maintain an ogram designed to provide a comfortable environment and development and transmission tion. Program ablish an Infection Control h it - trols, and prevents infections are individual resident; and d of incidents and corrective ections.	F 44	Corrective Action(s): CNA #1 has been inser use of PPE when rende residents on isolation, hinfection control practicare for resident #6. An Accident form was conincident. Identification of Defice Corrective Action(s): All residents on isolation potential to be affected of PPE, hand washing infection control techniand/or Unit Manager won residents on isolation infection control practicuse and hand washing care. Any negative find addressed immediately action taken as needed. and Accident form will each negative finding.	cring care to hand washing and ces during ADL in Incident & inpleted for each cient Practice(s) & on may have the by improper use and improper iques. The DON vill conduct audits on to observe proper ces, proper PPE during resident lings will be and disciplinary A facility Incident

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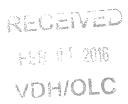
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495259	B. WING				01/13/2016
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2960 GRI	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614 PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION
F 441	determines that a reprevent the spread isolate the resident. (2) The facility must communicable disease from direct contact will tra (3) The facility must hands after each direct contact will tra hand washing is indeprofessional practice (c) Linens Personnel must hand transport linens so a infection. This REQUIREMEN by: Based on observation interview, facility docrecord review, the facestablished infection Residents, Resident	ion Control Program esident needs isolation to of infection, the facility must prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted e. dle, store, process and is to prevent the spread of T is not met as evidenced on, resident interview, staff sument review, and clinical cility staff failed to follow control guidelines for 1 of 26 #6.	F 4	!41	Systemic Change(s): The facility policy and procedures been reviewed and no changes are warranted at this time. All nursing will be inserviced on the facility policy and procedure on infection control include the proper use of PPE for residents on isolation by the DON a Regional Nurse consultant. Monitoring: The DON is responsible for maintal compliance. The DON, Unit Managand/or designee will perform rando weekly audits to monitor nursing st compliance. Any negative findings addressed at time of discovery and disciplinary action taken as warrant Findings of the audits will be report the QA Committee for review, anal and recommendations for change in facility policy, procedure, and/or pr Completion Date: 02-19-16	staff licy to and/or ining ger m aff for will ed. ed to ysis,	
	(methicillin-resistant CNA (certified nursin observed by the surv room with no PPE (p equipment) in place.	contact isolation for MRSA staphylococcus aureus). g assistant) #1 was eyor to be in Resident #6's					

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Event ID: 2CU411

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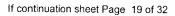
CENTERS FOR MEDICARE & MEDICAID SERVICES OM				D. 0938-0391				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495259	B. WING	A00-00-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	th Market and a shall and a shall and a shall are a sh	0.	1/13/2016	
	PROVIDER OR SUPPLIER GE HALL GRUNDY		an Managaman and the second and the	2966	ET ADDRESS, CITY, STATE, ZIP CO SLATE CREEK ROAD NDY, VA 24614		1710/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
	control) MRSA is a many antibiotics. Resident #6 was ad and was readmitted included, but were rand nares, gastroes diabetes, hypertens ulcer to right gluteus. Section C (cognitive quarterly MDS (miniwith an ARD (assess 12/28/15 scored the 15 points on the BIN status). Indicating the orientated. Section C coded to indicate the assistance of two stadressing. Eating was Resident was independent was independent to the Resident urostomy. The Residents CCP included the problem wound receiving zywnares receiving bact Approaches included provide contact preceiving contact preceivin	Imitted to the facility 06/25/14 on 01/08/16. Diagnoses not limited to, MRSA wound sophageal reflux disease, ion, and stage IV pressure is and sacrum. Improve patterns of the Residents imum data set) assessment is ment reference date) of Resident 15 out of a possible of Resident was alert and G (functional status) was a Resident required extensive aff for bed mobility and is coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel) was coded to indicate the endent with set up help only, and bowel was coded to indicate the endent with set up help only, and bowel was coded to indicate the endent with set up help only, and bowel was coded to indicate the endent with set up help only, and bowel was coded to indicate the endent with set up help only. The province of the province	F	.41				
	documented on 01/0	cluded a nursing entry 8/16 by LPN #3 that read in admitted back to facility, res						



clean and dry upon arrival @ approx.









DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	delegation of the second second second second			OMB NO	<u>0. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONST			ATE SURVEY EMPLETED
		495259	B. WING	ero-co-t-t-t-t-t-t-t-t-t-t-t-t-t-t-t-t-t-t		0.	1/13/2016
NAME OF	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
UEDITA	GE HALL GRUNDY			2966 SLA	TE CREEK ROAD		
ПЕКНА	JE HALL GRUNDT			GRUNDY	Y, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 441	medications with Dr requires isolation pr MRSA of nares and On 01/11/16 at appr surveyor observed a	45 (4:45 p.m.). Verified r (name omitted)Res recautions r/t (related to)	F4	41			
	gowns, gloves, and surveyor was able t surveyor was also a outside of the door	masks. Inside the room the o observe a red barrel. The able to observe a sign on the frame that read "Attention before entering room thank					
	surveyor observed (room. CNA #1 did n equipment. The sur moving Resident #6	roximately 1:05 p.m. the CNA #1 in Resident #6's ot have on any protective veyor observed CNA #1 i's over the bed table and int with her meal tray.					
	#1 about being in th CNA #1 verbalized t entered the room sh	om the surveyor asked CNA e room with no PPE in place. o the surveyor that when she he hadn't realized the resident er medical appointment.					
	surveyor applied PP room. Resident #6 v about her appointment	oximately 1:15 p.m. the E and entered the resident's was interviewed and asked ent. Resident #6 was then re PPE when entering her eplied that they did.					
	surveyor notified the	oximately 1:40 p.m. the corporate nurse that CNA #1 in Resident #6's room with no					



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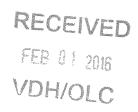
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495259	B. WING			01	/13/2016
	PROVIDER OR SUPPLIER GE HALL GRUNDY			2966	EET ADDRESS, CITY, STATE, ZIP CODE S SLATE CREEK ROAD JNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 20	F 44	11			
	copy of "CDC Guide Table 2." These guide Wound Infection Ab cannot be covered	e provided the surveyor with a eline for Isolation Precautions: delines read in part "Skin or scess or draining wound thatStaphylococcus aureus Contact Precautions"					
	surveyor interviewer nurse) #2. The DON identified LPN #2 as nurse and infection that Resident #6 had nares. When asked entering the room to to the surveyor that CNA #1's education	roximately 1:45 p.m. the d LPN (licensed practical I (director of nursing) had at the QA (quality assurance) control nurse. LPN #2 stated d MRSA in her wound and if she would expect staff to wear PPE LPN #2 verbalized she would. LPN #2 checked record and stated that CNA ced on infection control on					
	order resident require precautions related	ility staff added the physicians res contact isolation to MRSA of nares and sacral t POS (physician order					
	ADON (assistant direction control	OON (director of nursing), and ector of nursing) were notified ol issue regarding Resident the survey team on 01/12/16 5 p.m.					
F 502 SS=E			F 50	2	F502 Corrective Action(s):		

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Facility ID: VA0102

If continuation sheet Page 21 of 32



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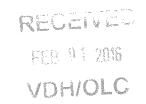
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495259	B. WING	:	01/13/2016	
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COD		
HERITA	SE HALL GRUNDY			2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		OULD BE COMPLETION	
F 502	services to meet the	ge 21 ovide or obtain laboratory e needs of its residents. The e for the quality and timeliness	F 5	Resident #7's attending physici been notified that the facility fa obtain a HgbA1c ordered by the physician. A Facility Incident & Accident form has been comple the missing labs. Resident #8's attending physici	uiled to e & eted for	
	by: Based on staff interview, the facility s (laboratory tests) as	IT is not met as evidenced view and clinical record taff failed to obtain labs ordered by the physician for the survey sample, Residents		been notified that the facility facilit	uiled to the obtain ne & eted for	
	1. For Resident #7, obtain the physician 2. For Resident #8, obtain PT/INR labs at The findings include 1. For Resident #7, HgbA1c lab tests the physician to be obta	the facility staff failed to ordered labs HgbA1c. the facility staff failed to as ordered by the physician. d. the facility failed to obtain at had been ordered by the ined every 3 months. No en obtained after 02/06/15.		Identification of Deficient Pra & Corrective Action(s): All other residents who had phy ordered lab tests may have pote been affected. A 100% audit of resident's lab orders will be comidentify residents at risk. All ne findings will be corrected at the discovery. The attending physic be notified of the missing labs, I obtained timely and labs obtained without a physician order. A factincident & Accident Form will be completed.	visician ntially f all npleted to egative time of itans will labs not ed	
	test that provides infindividual's average called blood sugar, or Resident #7 was add Diagnoses included, diabetes, chronic kid Alzheimer's disease, disease.	(hemoglobin A1c*) is a blood ormation about an level of blood glucose, also over the past 3 months. mitted to the facility 04/06/13. but were not limited to, ney disease, hypertension, and gastroesophageal reflux patterns) of the Residents		Systemic Changes: The facility policy and procedure been reviewed and no changes as warranted at this time. The labor tracking system has been review implemented to track and validate required lab work has been compared per physician order and policy as procedure. The DON and/or Nut Consultant will inservice all licer staff on physician ordered laboratesting, protocols, & tracking systused.	re ratory red and te that pleted nd rse nsed utory-	

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Event ID: 2CU411

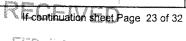
Facility ID: VA0102

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495259	B. WING			0.	1/12/2016
	PROVIDER OR SUPPLIER			29	TREET ADDRESS, CITY, STATE, ZIP CODE 966 SLATE CREEK ROAD RUNDY, VA 24614	1 0	1/13/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x :	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 502	with an ARD (asses 11/16/15 was coded had problems with I and was moderately for daily decision m diagnoses) included. The clinical record in 1. Current physician (physician order sur for the laboratory te MONTHS DX. (Diagnellitus)." 2. Original physician for "HgbA1C in amomonths" 3. Results of an Hgt 02/06/15. Results w 6.4 the reference rawas 4.5-6.2. The ph 02/06/15.	simum data set) assessment assent reference date) of d 1/1/2 indicating the Resident long and short term memory yimpaired in cognitive skills aking. Section I (active diabetes. Included the following. In signed (12/13/15) POS mmary) that included an order st "HGBA1C Q (every) 3 gnosis) DM (diabetes in signed order dated 02/05/15 dx. DM. HgBA1C every 3 DA1C lab test obtained on the lab ysician had signed this lab on interesting the signed order dated on the lab ysician had signed this lab on interesting the signed order dated on the lab ysician had signed this lab on interesting the signed order dated on the lab ysician had signed this lab on interesting the signed order dated on the lab ysician had signed this lab on interesting the signed this lab on the sign	F		Monitoring: The DON is responsible for maintainin compliance. The DON and/or designee will complete the Facility Lab audit too weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: 2-19-16	ol / e to	
: - - - -		nable to locate any HgbA1c e clinical record obtained					
2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3	control his blood sug- locate any informatic indicate the Residen hyperglycemic episo the eMARs (electron records) from March and was unable to fir	receiving any medications to gars. The surveyor did not on in the clinical record to thad any hypo and/or des. The surveyor reviewed ic medication administration 1, 2015-January 13, 2016 and any documentation on the perfacility staff had obtained					





DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	• 4-11 4			<u>)MB NO</u>) <u>. 0938-0391</u>
	FOF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495259	B. WING			01	/13/2016
NAME OF	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE HALL GRUNDY				SSLATE CREEK ROAD JNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	***************************************	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 502	Continued From pa	ge 23	F 5	n2			
		I sugar using the as needed	, ,	<i>02.</i> .			
	The DON (director of the missing lab result approximately 7:40						
;	DON verbalized to t	roximately 10:50 a.m. the he surveyor that Resident ad not been obtained after					
	ADON (assistant dir consultant were not	OON (director of nursing), rector of nursing), and nurse fied of the missing labs th the survey team on mately 1:55 p.m.					
		on regarding the missing ovided to the survey team erence.					
		as obtained from the website: gov/medlineplus/ency/article/					
	obtain PT/INR (proth normalized ratio) lab physician. The facilit lab test ordered on 1	the facility staff failed to prombin time/international is as ordered by the y failed to obtain a PT/INR 2/04/15 and failed to obtain I on 01/01/16 and 01/11/16 in					
	prothrombin time (P ⁻ measures the time it	ional Institute of Health a Γ) is a blood test that takes for the liquid portion od to clot. The most common					

reason to perform this test is to monitor your



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CENTE!	RS FOR MEDICARE	& MEDICAID SERVICES	****			OMB NO	D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING			(X3) DA	ATE SURVEY EMPLETED			
	ļ	495259	B. WING		1097-149-1488-1488-1488-1-8017-3-8017	01	1/13/2016
	PROVIDER OR SUPPLIER	And any consequence of the second sec			REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD	was and a second resemble and	THE RESERVE OF THE PROPERTY OF
HERITAC	GE HALL GRUNDY			GR	RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 502	medicine called war Resident #8 was ac Diagnoses included fibrillation, chronic of hypertension, gastro and BPH (benign proceed of the period of the physician order date physician by a physician was obtained order date ordered as physician was notificated fibration.	e taking a blood-thinning arfarin (coumadin). In the coumadin of the facility 07/27/15. In the coumadin of the coumadin of the coumand of the countant	F	602			

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coumadin 5 mg on 12/25/15 at bedtime. A review of the Residents eMAR's (electronic medication

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& MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		(X3) DATE SURVEY COMPLETED
495259	B. WING		01/13/2016
	I	STREET ADDRESS, CITY, STATE, ZIP CO	ODE 1 01/13/2010
		2966 SLATE CREEK ROAD GRUNDY, VA 24614	
Y MUST BE PRECEDED BY FULL	ID PREFI TAG	PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
rds) indicated the medication restarted per the physician's 31/15 to "Collect PT/INR in o results in the clinical record d lab test. The clinical record R obtained on 01/03/16. In ented as PT 65.3 and INR in on this lab indicated the lab acility and reported the lab acility and reported the lab an was notified on 01/03/16 re given from the physician to mg PO (by mouth) Q (every) if sleep) until further orders MP (comprehensive metabolic ete blood count), PT/INR in ere obtained as ordered on ed to the physician. The re documented as 5.19. The ablood count) was at 3.80, hemoglobin was at 11.5, and hematocrit was at 35.5. The previous RBC is was documented as 3.09, I hematocrit as 30.2. hemoglobin, and hematocrit ince 09/15. otified on 01/04/16 of the lab ers were obtained on to hold coumadin and repeat. This lab was obtained as and INR (2.53). The physician esults on 01/06/16 and new it to "Start coumadin 3 mg po R on 1/11/16."	F 5	02	
	A95259 ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) age 25 rds) indicated the medication restarted per the physician's B1/15 to "Collect PT/INR in oresults in the clinical record d lab test. The clinical record R obtained on 01/03/16. mented as PT 65.3 and INR in on this lab indicated the lab acility and reported the lab an was notified on 01/03/16 re given from the physician to mg PO (by mouth) Q (every) f sleep) until further orders MP (comprehensive metabolic ete blood count), PT/INR in ere obtained as ordered on ed to the physician. The re documented as 58.9 and a documented as 5.19. The blood count) was at 3.80, hemoglobin was at 11.5, and hematocrit was at 35.5. The previous RBC was documented as 3.09, I hematocrit as 30.2. hemoglobin, and hematocrit ince 09/15. otified on 01/04/16 of the lab ers were obtained on to hold coumadin and repeat This lab was obtained as and INR (2.53). The physician esults on 01/06/16 and new of to "Start coumadin 3 mg po R on 1/11/16."	A BUILD A95259 RITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) AGE A195259 RITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) A195259 B10 B21 B225 B23 B31/15 to "Collect PT/INR in or results in the clinical record dorseld allowed to a continuous in the clinical record dorseld allowed to a continuous in the lab and was notified on 01/03/16. The clinical record does not be a continuous in the physician to a company of the physician to a company of the physician to a continuous in the physician to a company of the physician. The record documented as 5.19. The ablood count) was at 3.80, hemoglobin was at 3.80, hemoglobin was at 3.5. The previous RBC 5 was documented as 3.09, hematocrit as 30.2. hemoglobin, and hematocrit was at 35.5. The previous RBC 5 was documented as 3.09, hematocrit as 30.2. hemoglobin, and hematocrit ince 09/15. offied on 01/04/16 of the lab are were obtained on to hold coumadin and repeat This lab was obtained as and INR (2.53). The physician are sults on 01/06/16 and new do in "Start coumadin 3 mg po	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CO 2966 SLATE CREEK ROAD GRUNDY, VA 24614 ATEMENT OF DEFICIENCIES IN MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) TAG TO CROSS-REFERENCED TO THE ADDRESS TO CROSS-REFERENC

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PT/INR ordered to be obtained on 01/11/16. The DON (director of nursing) did provide the

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	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
:	495259	B. WING	national and a second s	1004000 km	01/13/2016	
			2966	SLATE CREEK ROAD		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG	X ;	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION	
rveyor with a cop 1/12/16. The resul 1.4) and INR (1.8 d new orders were rease coumadines and 3 mg/s. Repeat PT/IN 01/12/16 the DC obtaining labs. To veyor that the order a lab book and the s. The DON state ain the labs the faining the labs. Tow why the labs wing a meeting with 13/16 at approximal approximal and nurse missing PT/INR ordered on 01/11/16. Resident was of surveyor during a no problems were surveyor during and problems and problems were surveyor during and problems and problems were surveyor during and problems were surveyor durin	y of a PT/INR obtained on the were documented as PT 7). The physician was notified the obtained on 01/12/16 to to 4 mg at bedtime on of coumadin on all other R on 01/26/16. When we asked the procedure the DON verbalized to the ders for the labs were placed the hospital would obtain the edithat if the hospital did not accility was responsible for the DON added she did not were not obtained as ordered. The DON (assistant director of consultant were notified of lab test on 12/04/15, the 01/01/16 was not obtained the PT/INR ordered to be 6 was not obtained until observed numerous times by the course of survey process are identified.	F 5	02:			
INR lab tests was to the exit conformation (I)(1) RES CORDS-COMPL at facility must ma	s provided to the survey team erence. ETE/ACCURATE/ACCESSIB intain clinical records on each	F 5	14*	F514 Corrective Action(s):		
	entinued From parveyor with a copy (12/16. The result) (1.4) and INR (1.8) and rease coumading esdays and 3 mg and sesdays and the labs the faining the labs the faining the labs which the labs with the labs with the session of the sesdent was on the sesdent	A95259 JOER OR SUPPLIER JALL GRUNDY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 26 Preyor with a copy of a PT/INR obtained on 1/12/16. The results were documented as PT 0.4) and INR (1.87). The physician was notified down orders were obtained on 01/12/16 to rease coumadin to 4 mg at bedtime on esdays and 3 mg of coumadin on all other lays. Repeat PT/INR on 01/26/16. 01/12/16 the DON was asked the procedure obtaining labs. The DON verbalized to the reveyor that the orders for the labs were placed a lab book and the hospital would obtain the set. The DON stated that if the hospital did not again the labs. The DON added she did not one why the labs were not obtained as ordered. Find a meeting with the survey team on 13/16 at approximately 1:55 p.m. the ministrator, DON, ADON (assistant director of sing), and nurse consultant were notified of missing PT/INR lab test on 12/04/15, the 1/2/16 was not obtained in 01/03/16, and the PT/INR ordered to be alined on 01/11/16 was not obtained until 12/16. Resident was observed numerous times by surveyor during the course of survey process in no problems were identified. further information regarding Resident #8's INR lab tests was provided to the survey team on to the exit conference.	A BUILD A 95259 B. WING A 95259 B. WING A 95259 B. WING A BUILD A 95259 B. WING A BUILD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 26 INTERPRETATION INTINUED FROM 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	A BUILDING 495259 B. WING SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Intinued From page 26 reveyor with a copy of a PT/INR obtained on 1/2/16. The results were documented as PT 0.4) and INR (1.87). The physician was notified donew orders were obtained on 01/12/16 to rease coumadin to 4 mg at bedtime on easted as and 3 mg of coumadin on all other yes. Repeat PT/INR on 01/26/16. 01/12/16 the DON was asked the procedure obtaining labs. The DON verbalized to the veyor that the orders for the labs were placed a lab book and the hospital would obtain the s. The DON stated that if the hospital did not ain the labs the facility was responsible for aining the labs. The DON added she did not low why the labs were not obtained as ordered. Fing a meeting with the survey team on 13/16 at approximately 1:55 p.m. the ministrator, DON, ADON (assistant director of sing), and nurse consultant were notified of missing PT/INR lab test on 12/04/15, the INR ordered on 01/01/16 was not obtained ii 01/03/16, and the PT/INR ordered to be ained on 01/11/16 was not obtained until 12/16. PREFIX TAGE A BUILDING B. WING PREFIX TAGE F 502 F 503 F 503 F 503 F 503 F 504 F 503 F 504 F 507 F 508 F 508	ABUILDING 495259 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614 SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD RECOLLARD FROM STATE APPROPRIATION) Intinued From page 26 reyor with a copy of a PT/INR obtained on 1/2/16. The results were documented as PT 14) and INR (1.87). The physician was notified do new orders were obtained on 01/12/16 to rease coumadin to 4 mg at bedtime on esdays and 3 mg of coumadin on all other ys. Repeat PT/INR no 01/12/16 to the obtaining labs. The DON verbalized to the veyor that the orders for the labs were placed a lab book and the hospital would obtain the s. The DON stated that if the hospital did not ain the labs the facility was responsible for aining the labs. The DON added she did not ow why the labs were not obtained as ordered, ring a meeting with the survey team on 13/16 at approximately 1:55 p.m. the ministrator, DON, ADON (assistant director of sing), and nurse consultant were notified of missing) and nurse consultant were notified of missing PT/INR lab test on 12/04/15, the INR ordered on 01/01/16 was not obtained until 12/16. Resident was observed numerous times by surveyor during the course of survey process In oproblems were identified. F514 F514 F514 Corrective Action(s):	

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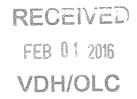
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495259	B. WING			0	1/13/2016
NAME OF	PROVIDER OR SUPPLIER			[;	STREET ADDRESS, CITY, STATE, ZIP CODE		
				;	2966 SLATE CREEK ROAD		
HERITAC	SE HALL GRUNDY			(GRUNDY, VA 24614		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	- al	<u></u>	PROVIDER'S PLAN OF CORREC	ION	(X5)
PREFIX TAG	*	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE OPRIATE	COMPLETION DATE
					Resident #1's attending physician		
F 514	Continued From pa	ge 27	F 5	514	been notified of the inaccuracy wi		:
	standards and prac	tices that are complete;			resident's gender in the progress n	ites	
		nted; readily accessible; and			and the progress notes have been corrected. A facility incident and a	ecident	:
	systematically orga				form has been completed for this i		
					torm has been completed for and t		
	The clinical record i	must contain sufficient			Resident #11's attending physician	has	
	information to ident	ify the resident; a record of the			been notified that the facility staff		
		ents; the plan of care and			to correctly date a physician teleph	one	
	services provided; t				order to draw a physician ordered		
		ning conducted by the State;			lab on the directed day, Friday. Th		
	and progress notes	•			was obtained on Monday, 3 days l		
					facility incident and accident form	has	;
i		:			been completed for this incident.		:
		NT is not met as evidenced			Resident #13's code status has been	1	
•	by:				reviewed by the attending physicia		
		rview, facility document review			she is a DNR. The physician order		
		eview, it was determined that			physician progress note reflects th		
:		d to maintain a complete and			correct code status. A facility Incid		1
		cord for 3 of 26 residents in			Accident form was completed for	ach	*
		(Residents #1, 11 and 13). nical record contained			incident.		
						_	
	inaccurate physiciar	linical record contained an			Identification of Deficient Practi	es &	
					Corrective Action(s):	dialla.	
	physician order.	y test draw and an undated			All other residents may have poter been affected. A 100% audit of res		;
		linical record contained an			medical records for the last 30 day		
	inaccurate Plan of C				be conducted by the DON and AD		
	macourate riant or c	, and the second			identify residents at risk for inaccu	rate	
•	The findings include	d:			documentation and inaccurate Coo		
		readmitted to the facility on			Status. All negative findings will b	e	
		resident was originally			clarified and/or corrected as applic	able at	,
:		ty on 2/20/15. Resident #1			time of discovery and the attendin	•	
		agnoses of, but not limited to			physician notified of the incident.	A :11 h -	
:	ascites, heart failure				facility Incident & Accident form	viii de	;
:		(Minimum Data Set, an			completed for each negative finding	Ŗ.	
:		l) with an ARD (Assessment					:
	-	1/13/16 coded Resident #1			÷		
:		nterview for Mental Status)			· .		
		5, indicating the resident was			•		
:		Resident #1 was also coded			\$		

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

Event ID: 2CU411

Facility ID: VA0102

If continuation sheet Page 28 of 32



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

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO	<u>). 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B. WING			01	I/13/2016
NAME OF	PROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
			I	2	966 SLATE CREEK ROAD		
HERITAC	GE HALL GRUNDY			G	GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)) BE	(X5) COMPLETION DATE
F 514	members for bathin During Resident #1 1/12/16, the physici documented under X (times) three whith distress" These documented with R The progress notes the above statemer 8/26/15, 8/29/15, 9/11/24/15. Resident with ARD dates of 1 Section A0800 as b In the conference rothe surveyor information above documented nurse stated "We have the administrator, of director of nursing a notified, of the above above, on 1/12/16 a room. No further information surveyor prior to the 2. Resident # 11 was 11/23/15 with the follimited to status posanxiety, high choles heart disease, depression of the surveyor prior to the surveyor disease, depression and the progression of the status posanxiety, high choles heart disease, depression and the progression of the surveyor prior to the surveyor prior t	we assistance by 2 staff g and dressing. Its clinical record review on an's progress notes Examination, "Alert, oriented e female not in any acute progress notes were esident #1's name on them. It were documented with at were dated for 8/11/15, 23/15, 10/1/15, 10/8/15 and #1 was coded, on the MDS 1/25/15 and 1/13/16, in eing a "Male". Soom on 1/12/16 at 11:30 am, and the corporate nurse of the findings. The corporate ave got to get that fixed". Ilirector of nursing, assistant and the corporate nurse were e findings as documented to 5 pm in the conference On was provided to the exit conference on 1/13/16. It is admitted to the facility on lowing diagnoses of, but not the fracture hip, weakness, terol, high blood pressure, essive disorder and dementia.	F 5	i14	1	e the and urate n in ders, l e to ive l at on ty	
	1/12/16, it was noted	's clinical record review on d a physician order was not se wrote the order. This order					

was in between the orders that were dated for 12/22/15 and 12/28/15. The order documented,



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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		TE SURVEY MPLETED
		495259	B. WING		PPRINTED TO THE PRINTED TO THE PRINTED THE PRINTED TO THE PRINTED	01	/13/2016
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HALL GRUNDY				6 SLATE CREEK ROAD UNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 514		sive Metabolic Panel) Friday	F (514			
	the surveyor showed the undated order in	in the B wing nurses' station, d RN (registered nurse) #5 n the clinical record of #5 stated, "I forgot to date the					
	Resident #5, it was results section a CM was drawn by the la was on a Monday. Friday for a CMP in	of the clinical record of noted in the laboratory test IP (complete metabolic panel) b staff on 12/28/15, which There was no lab result on a the clinical record for the ntil 12/28/15, which was the lrawn on.					
	director of nursing, a	irector of nursing, assistant and corporate nurse was documented findings on e conference room.					
	gave the surveyor a "Telephone Orders". "Verbal telephone or each resident's Atter "Policy Interpretation policy the following v 1. " Verbal telephone received by licensed 2. The entry must co	e orders may only be personnel portain the instructions from			REC		
		ime and the signature and necession and necession and the information "				2015	

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

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495259	B. WING	sinamainamanana		01	1/13/2016
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HALL GRUNDY				66 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 514	3. Resident #13 was 6/8/15 with the follo limited to dementia, depressive disorder Resident #13 was control Data Set, an assess (Assessment Refer having short term a problems. Resident meeding extensive a members for bathin During review of Resident for the FNP (Family Nut) (Power of Attorney). Clinical record it was of Care) dated for the FNP (Family Nut) (Power of Attorney). Clinical record it was of Care) dated for the FNP (Family Nut) (Power of Attorney). Clinical record it was of Care) dated for the Surveyor on 1/12/16 attorney on 1/12/16 station on the C wing "I don't know when the thought that we had doctor) hadn't signed anything written down, in the same nutrol power in the same	as admitted to the facility on wing diagnoses of, but not osteoporosis, anxiety, major and high blood pressure. I coded on the MDS (Minimum sment protocol) with an ARD ence Date) of 11/30/15 as not long term memory to #13 was also coded as assistance with 2 staffing and dressing. I sident #13's clinical record on a rable Do Not Resuscitate or 6/8/15 and was signed by the result of the pool of the second of the pool of the second of the pool of the second of the pool o	F 5	114			
	On 1/12/16 at 5 pm	in the conference room, the					

administrator, director of nursing, assistant director of nursing and corporate nurse was notified of the above documented findings.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495259	B. WING		01/13/2016
NAME OF PROVIDER OR SUPPLIES HERITAGE HALL GRUNDY	3		STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614	
PREFIX (EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION

F 514 Continued From page 31

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

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VDH (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING __ 01/13/2016 B. WING VA0102 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2966 SLATE CREEK ROAD HERITAGE HALL GRUNDY GRUNDY, VA 24614 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 000 F 000 Initial Comments An unannounced biennial State Licensure Inspection was conducted 01/11/16 through 01/13/16. Corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Residents #1 through #20) and 6 closed record reviews (Residents #21 through #26). F 001 F 001 Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities. 12 VAC 5-371-140. Resident Behavior & Facility Practices. 12 VAC 5-371-140 (A,D.12,E.2,E.3): Cross reference to F-226. 12 VAC 5-371-220. Quality of Care. RECEIVED
VDH/OLC 12 VAC 5-371-220 (A THRU G) Cross reference to F-309. 12 VAC 5-371-300. Pharmacy Services. 12 VAC 5-371-300 (A,C,G) Cross reference to F-425.

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

12 VAC 5-371-180 (A,B,C) Cross reference to

12 VAC 5-371-180. Infection Control.

TITLE

(X6) DATE

F-441.

FORM APPROVED VDH (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING __ 01/13/2016 B. WING VA0102 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2966 SLATE CREEK ROAD HERITAGE HALL GRUNDY GRUNDY, VA 24614 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 001 F 001 Continued From Page 1 12 VAC 5-371-310. Administration. 12 VAC 5-371-310 (A) Cross reference to F-502. 12 VAC 5-371-360. Clinical Records 12 VAC 5-371-360 (A,E,f,j) Cross Reference to F-514

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