

HERITAGE HALL - LAUREL MEADOWS Our Home, Our Family, Our Life, Too.

March 14, 2016

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

Mr. Miller,

Attached to this cover letter you will find Heritage Hall - Laurel Meadows 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) 398-2117.

Sincerely,

Wrightly Darnell Administrator

Wrightly Darnell

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	survey was conducted on the census in this cat the time of the succession of the census (Residents #1 through reviews (Residents #1 through).	60 certified bed facility was 56 survey. The survey sample rent Resident reviews 19h #12 and 3 closed record 1413 through #15).				
		TO REFUSE; FORMULATE	F 155			
	refuse to participate and to formulate an	e right to refuse treatment, to in experimental research, advance directive as ph (8) of this section.		F155 Corrective Action(s): Resident's #10 & #11 have had their DDNR form and physician orders reviewed by the attending physician they have been updated and correctly	and	
	specified in subpart related to maintainin procedures regardin requirements include provide written infort concerning the right or surgical treatment option, formulate an includes a written de	Inply with the requirements of I of part 489 of this chapter in grant with a policies and grant advance directives. These is provisions to inform and mation to all adult residents to accept or refuse medical and, at the individual's advance directive. This escription of the facility's tradvance directives and		completed to reflect resident #10 & # code status. An Incident and Accident form was completed for this incident Identification of Deficient Practices Corrective Action(s): All other residents may have been potentially affected. The Admission Director will review all resident's me records and contact all responsible pato verify each resident code status and advance directives to insure that the proper status has been explained and written notification has been placed in medical record.	#11's ht (s) & dical prties d	

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

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 tays 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.

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

Event ID RGUB11

Facility ID: VA0105

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review the facility staff failed to ensure an accurate DNR (do not resuscitate) status for 2 of 15 Residents, Resident #10 and #11.

The findings included:

1. For Resident #10, the facility staff failed to correctly code the DNR status on the physician's order summary.

Resident #10 was admitted to the facility on 02/19/16. Diagnoses included but not limited to hypothyroidism, gastroesophageal reflux disease and pathological fracture.

There is no MDS (minimum data set) completed at this time. Resident #10's clinical record was reviewed on 02/24/16. It contained a completed Virginia Department of Health DDNR (durable do not resuscitate) form signed and dated 02/22/16. The Resident's clinical record also contained a POS (physician's order summary) dated 02/19/16, which read in part "full code".

The surveyor spoke with the DON (director of nursing) and nurse consultant on 02/24/16 at approximately 10:00 regarding the inconsistency of the DNR status. The DON and nurse consultant could not locate information that showed the Resident's change in code status.

The concern of the inconsistent DNR status was brought to the attention of the administrative staff during a meeting on 02/24/16 at approximately 1130.

F 155

Systemic Change(s);

The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director has been in-serviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record.

Monitoring:

The Admission Director is responsible for maintaining compliance. The Admission Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation.

Completion Date: April 8, 2016

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The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.

Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:

Based upon staff interview and clinical record review, the facility staff failed to have an accurate MDS assessment for 1 of 15 Residents in the survey sample (Resident #12). The findings included:

The staff failed to have correctly code a flu vaccine on the MDS on Resident #12 when admitted to the facility.

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Corrective Action(s):

Resident #12's Admission MDS with an ARD of 2/17/16 was reviewed by the RCC and a modification was completed to accurately code section O for Flu Vaccine on the MDS. A facility Incident & Accident form was completed for this incident.

Identification of Deficient Practice(s) and Corrective Action(s):

All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the RCC and/or designee to ensure that MDS section O – Flu Vaccine is assessed and coded correctly. All negative findings will be reported to the RCC for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.

Systemic Change(s):

The Resident Interdisciplinary Care Team have been in-serviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include section O of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data.

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F 309	2/10/16 with the foll limited to acute respressure, diabetes, admission MDS (Massessment protocon Reference Date) of as having a BIMS is score of 15. The reassistance by staff hygiene and total debathing. During the clinical rewas noted on the Micoded under Section received the fluivac same section of the as a "1" which reput this facility during the vaccination season. On 2/24/16 at approdirector of nursing was notified of the anurse stated, "That coded this as a 1 instructions with the surveyor prior to the 483.25 PROVIDE CHIGHEST WELL BE Each resident must provide the necessary or maintain the higher mental, and psychostics."	admitted to the facility on owing diagnoses of, but not biratory failure, high blood edema and gout. The inimum Data Set, an ol) with an ARD (Assessment 2/17/16 scored the resident core of 12 out of a possible sident requires extensive for dressing and personal ependence on staff for ecord review on 2/24/16, it DS that the resident was in "O" as not having cine in this facility. In the MDS, the resident was coded oresents the resident not in is year's influenza eximately 11:20 am in the soffice, the corporate nurse bove findings. The MDS person stead of a 2." In was provided to the exit conference on 2/24/16. ARE/SERVICES FOR EING Treceive and the facility must ry care and services to attain est practicable physical,	F:	monitoring coassessment au weekly coinci to monitor for findings from to the DON ardiscovery for Aggregate find Quality Assurfor review, and recommendati policy, proced Completion E	I RCC are responsible for ompliance. The MDS adit will be completed iding with the MDS calendar compliance. All negative the audits will be reported and RCC at the time of immediate correction. dings will be reported to the rance Committee monthly alysis, and ions for change in facility dure, and/or practice. Date: April 8, 2016	

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Event ID RGUB11

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This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record review, the facility staff failed to follow physician orders for 3 of 15 Residents, Resident #4, #5, and #11

The findings included.

1. For Resident #4, the facility staff failed to administer mucinex as ordered by the physician and failed to follow the bowel protocol.

Resident #4 was admitted to the facility 04/07/15. Diagnoses included, but were not limited to, cerebrovascular disease, diabetes, depressive disorder, anxiety disorder, chronic obstructive pulmonary disease, and shortness of breath.

Section C (cognitive patterns) of the Residents admission (readmission) MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/21/16 scored the Resident 9 out of a possible 15 points. Section G (functional status) was coded 3/3 for extensive assistance of 2 people for toilet use. Section H (bowel continence) was coded to indicate the Resident was always continent of bowel.

The Residents clinical record included a physicians order dated 02/11/16 for mucinex 600 mg (milligrams) PO (by mouth) q (every) 12 hours

A review of the Residents eMAR (electronic medication administration) for the month of February 2016 indicated the Resident only received the mucinex one time a day.

F 309

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Corrective Action(s):

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DEFICIENCY)

Resident #4's attending physician was notified that the facility failed to administer Mucinex as ordered or follow the bowel protocol as ordered by the attending physician. A facility Incident and Accident form was completed for this incident.

Resident #5's attending physician was notified that the facility staff failed to follow the bowel protocol as ordered by the physician. A facility Incident and Accident form was completed for this incident.

Residents #11's attending physicians were notified that the facility failed to use the physician ordered wedge when up in wheel chair. A facility Incident and Accident form was completed for this incident.

Identification of Deficient Practices/Corrective Action(s):

All other residents may have been potentially affected. The DON, and Unit Manager will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.

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	(director of nursing) notified of that the r	roximately 9:40 a.m. the DON and nurse consultant were nucinex was given one time a 2 hours as ordered by the		Systemic Change(s): Facility policy and procedure reviewed. No revisions are we this time. The nursing assess as evidenced by the 24 Hour	varranted at nent process
		roximately 10:15 a.m. the the surveyor that the mucinex stem incorrectly.		documentation in the medical physician orders remains the document for the developmer monitoring of the provision o	record / source nt and
	A review of the Residents BM's (bowel movements) for February 2016 indicated the Resident had a BM on 02/11/16 and did not have another BM until 02/16/16.			includes, obtaining, transcrib completing physician medica & treatment orders. The DON Regional nurse consultant wi all licensed staff on the proce	ing and tion orders I and/or Il in-service dure for
	200 mg everyday fo physicians order for	rd colace 100 mg 2 tablets r constipation and had a miralax powder mix 17 ice PO BID (twice a day) PRN ation.		obtaining, transcribing, and c physician ordered medication treatment orders. Monitoring: The DON will be responsible	and

The facility used standing orders for constipation "MOM (milk of magnesia) 30 cc PO daily X 3 days. If no BM on 4th day give Dulcolax suppository one per rectum; if no results after 1 hr., give Fleets enema per rectum. If constipation recurs q3 days routinely, you may begin Senokot-S 1 tab PO twice daily and use above interventions p.r.n." (sic)

There was no documentation on the eMAR to indicate the bowel protocol had been followed or that the prn miralax had been administered from 02/11/16-02/16/16.

On 02/23/16 at approximately 11:40 a.m. the DON was notified that per the clinical record Resident #4 had not had a BM from 02/11/16 until

The DON will be responsible for maintaining compliance. The DON,

and/or Unit Manager will audit/review all MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time 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: April 8, 2016

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	meeting with the ac (assistant director of consultant the adm that the Residents in	roximately 4:40 p.m. during a lministrator, DON, ADON of nursing), and nurse inistrative staff were notified mucinex was not given as wel protocol was not followed.					
		on regarding Resident #4 was yey team prior to the exit					
	2. For Resident #5, the bowel protocol.	the facility staff failed to follow			,		
	Diagnoses included	Imitted to the facility 12/22/13. I but were not limited to, sion, tachycardia, and					
	annual MDS (miniman ARD (assessme scored the Residen Section G (function toilet to use to indicextensive assistance)	e patterns) of the Residents num data set) assessment with nt reference date) of 12/09/15 t 5 out of a possible 15 points al status) was coded 3/2 for ate the Resident required se of one person. Section H was coded to indicate the vs continent of bowel.			RECEIVEL)	
	included the probler impaired bowel mot physical mobility. G	(comprehensive care plan) m/need area at risk for ility related to impaired oals included will have a BM days over the next quarter.			VDH/OLC		

Approaches included monitor BM documentation daily, document BM's daily, encourage fluids, and

encourage good po (by mouth) intake.

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	January 2016 indic	sidents bowel report for cated Resident #5 had a BM on ot have another BM until						
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There was no documentation on the eMAR to indicate the bowel protocol had been followed.

interventions p.r.n." (sic)

The DON (director of nursing) was notified of the above on 02/23/16 at approximately 11:40 a.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #11, the facility staff failed to apply the Residents wedge as ordered by the physician.

Resident #11 was admitted to the facility 01/25/16. Diagnoses included, but were not limited to, chronic kidney disease, dementia, hypertension, benign prostatic hyperplasia, dysphagia, and congestive heart failure.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/01/16 was scored 1 out of a possible 15

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	included the proble Approaches include incline wedge to be	P (comprehensive care plan) em/need area of falls, ed, but were not limited to, e placed in w/c (wheelchair) to chair and prevent sliding				
	(02/0416) order dat	included a signed physicians ted 01/28/16 for "Incline d in W/C to keep hips back in sliding forward."				
	surveyor and the Dechecked the Resident place. The Resident	proximately 9:00 a.m. the PON (director of nursing) ent to see if the wedge was in the was observed to be up in his lige was not in place.				
	ADON (assistant did consultant on 02/24 a.m. the administrat Resident #11 did no	with the administrator, DON, rector of nursing), and nurse 1/16 at approximately 11:25 tive staff were notified that but have their physician ordered en checked by the surveyor				
		on regarding this issue was yey team prior to the exit				
	483.60(a),(b) PHAR ACCURATE PROC	RMACEUTICAL SVC - EDURES, RPH	F 42	25		
		ovide routine and emergency ils to its residents, or obtain				

PRINTED: 03/04/2016

HUMAN SERVICES			FORM APPROVI	
(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED	ununu
495323	B WNG		02/24/2016	
ows		STREET ADDRESS, CITY STATE, ZI 16600 DANVILLE PIKE LAUREL FORK, VA 24352		nonement of the second
BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE COMPLÉTIC HE APPROPRIATE DATE	NC
and the services of the provided consultation of pharmacy and met as evidenced or pharmacy and met as evidenced or provides consultation of pharmacy and met as evidenced or provided companies or pharmacy and met as evidenced or provided companies or pharmacy and met as evidenced or provided companies or pharmacy and met as evidenced or provided companies or pharmacy and met as evidenced or provided companies or pharmacy and met as evidenced or pharmacy and met as evide		Corrective Action(s): Resident #2's attending been notified that the far ensure that physician or Robitussin CF was avar pharmacy for administration #2. A facility Incident that been completed for Identification of Defice Corrective Action(s): All residents may have affected. A 100% review medication regimes has by the DON, and/or Unidentify residents at rist to be at risk due the medication that the physicians we facility Incident and Action and Action of the physicians we facility Incident and Action of the physicians we facility Incident and Action of the physician of the ph	acility failed to refered medication ilable from ration to Resident and Accident form this incident. The this incident is seen to a seen this incident is the this incident. The this incident is seen this incident. The this incident.	
	EDICAID SERVICES PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER 495323 DWS IT OF DEFICIENCIES PRECEDED BY FULL INTIFYING INFORMATION) Int described in The facility may permit administer drugs if State der the general nurse. Inarmaceutical services at assure the accurate ensing, and is and biologicals) to meet int. For obtain the services of no provides consultation vision of pharmacy In the services of no provides consultation vision of pharmacy The facility document is available for residents in the survey Robitussin CF as on 1/14/16 from the serviced to the facility on	EDICAID SERVICES PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER 495323 B WING WY OF DEFICIENCIES BE PRECEDED BY FULL NTIFYING INFORMATION) Int described in The facility may permit administer drugs if State der the general nurse. Interpretation and is and biologicals to meet and interpretation of provides consultation vision of pharmacy Interpretation of pharmacy ID PREFIT TAG F 4 Int described in The facility may permit administer drugs if State der the general nurse. Interpretation of the services of the provides consultation vision of pharmacy Interpretation of pharmacy Robitussin CF as on 1/14/16 from the	A 95323 A WING STREET ADDRESS, CITY STATE, ZI 16600 DANVILLE PIKE LAUREL FORK, VA 24352 AT OF DEFICIENCIES BE PRECEDED BY FULL TAG CROSS-REFERENCED TO TO DEFICIENCY A 10 PREFIX CACH CORRECTIVE ACTION DEFICIENCY A 10 PREFIX CROSS-REFERENCED TO TO DEFICIENCY A 25 PROVIDER'S PLAN OF CROSS-REFERENCED TO TO DEFICIENCY A 25 PROVIDER'S PLAN OF CROSS-REFERENCED TO TO DEFICIENCY A 25 PROVIDER'S PLAN OF CROSS-REFERENCED TO TO DEFICIENCY A 26 STREET ADDRESS, CITY STATE, ZI 16600 DANVILLE PIKE LAUREL FORK, VA 24352 A 24352 F 425 F 425 F 425 F 425 F 425 Corrective Action(s): Resident #2's attending been notified that the firensure that physician on Robitussin CF was away pharmacy for administe #2. A facility Incident and has been completed for a for provides consultation affected. A 100% review medication regimes has by the DON, and/or Unidentify residents at ris to be at risk due the munavailable from the procrected at time of dis attending physicians we facility Incident and A been completed for each savailable for residents in the survey Robitussin CF as on 1/14/16 from the ted to the facility on timely from the pharm	### PA25 ### PA

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limited to chronic shortness of breath, chest pain,

congestive heart failure, depression, Parkinson 's

Disease and Rheumatoid Arthritis. Resident #2 MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 12/9/15 coded the resident

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Facility ID: VA0105

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take should a medication not be delivered

timely from the pharmacy.

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION			LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495323	B WING		0.2	/24/2016	
	PROVIDER OR SUPPLIER GE HALL - LAUREL M	EADOWS		STREET ADDRESS CITY STATE ZIP CO 16600 DANVILLE PIKE LAUREL FORK, VA 24352			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 425	was having a BIMS Status) score of 11 Resident #2 was alsextensive assistance personal hygiene are on staff for bathing. During the clinical rewas noted that the flavor was noted to have flavor was not was no	(Brief Interview for Mental out of a possible score of 15. so coded as requiring e with 2 staff members for not requiring total dependence ecord review on 2/23/16, it ollowing physician's order the clinical record which obitussin CF 10 ml (milliliters) three times a day) & q (every) ded) cough for 7 days". In ed and timed for 1/14/16 at edocumented the following: "hay start Robitussin CF when (pharmacy) MD (medical ponsible party) aware". On an Administration Record) 016, this medication was not at 6 am. ximately 4 pm, the director of urse and administrator of the findings. The director of estaff is to call the pharmacy obtain the medication. If for armacy cannot deliver the dy fashion, we do have a back es can use to get medicine or asked for the policy on as from the pharmacy. 5 pm, the director of nursing yor the policy titled "LTC Pharmacy Products and macy". Under the Procedure it stated the following: sary medication is not	F 4	Monitoring: The DON is responsible for compliance. The DON and Manager will conduct med of resident medication order coinciding with the Care procheck for the availability of drugs. All negative finding corrected at the time of districted at the time of districted at the quality Assurance Confereivew, analysis, and reconfor change in facility policy and/or practice. Completion Date: April 8	Vor Unit lication reviews ers each week lan calendar to f all ordered swill be covery. be reported to amittee for nmendations y, procedure,		

interim/stat/emergency supply, and the Facility determines that an interim/stat/emergency

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CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	Į.	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495323	B WING		02/24/2016	
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS CITY STATE, ZIP CODE	ULILAILUIV	
HERITA	GE HALL - LAUREL M	IEADOWS	16600 DANVILLE PIKE LAUREL FORK, VA 24352			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 502 SS=D	Continued From page 12 delivery is necessary, Facility should arrange either: 2.1 With the Pharmacy to include the interim/stat/emergency medication(s) in an earlier scheduled delivery or a special delivery, as required, or 2.2 For delivery by contract courier, or, 2.3 For the medication to be dispensed and delivered by a Third Party Pharmacy to ensure timely receipt " No further information was provided to the surveyor prior to the exit conference on 2/24/16. 483.75(j)(1) ADMINISTRATION		F 425			
	The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered lab tests for 1 of 15 Residents, Resident #3. The findings included. The facility staff failed to obtain the physician ordered lab tests BMP (basic metabolic panel), CBC (complete blood count), and magnesium. Resident #3 was admitted to the facility 07/07/15. Diagnoses included, but were not limited to, heart failure, hypertension, chronic kidney disease, diabetes, and cluster headaches			Corrective Action(s): Resident #3's attending physical been notified that the facility obtain a BMP, CBC and a Malevel ordered by the physicial Facility Incident & Accident been completed for the missical Identification of Deficient Pactor Action(s): All other residents who had produced lab tests may have probeen affected. A 100% audit resident's lab orders will be condented in the corrected at the discovery. The attending physical be notified of the missing lab obtained timely and labs obtained timely and labs obtained without a physician order. A Incident & Accident Form without a completed.	refailed to dagnesium an. A form has ing labs. Practice(s) Oblysician otentially to fall completed to negative the time of sicians will is, labs not ained facility	

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DEPA	RTMENT OF HEALTH	AND HUMAN SERVICES			PRINTED: 03/04/20	
CENT	ERS FOR MEDICARE	& MEDICAID SERVICES			FORM APPROV	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
		495323	B WING		02/24/2016	
NAMEO	F PROVIDER OR SUPPLIER			STREET ADDRESS CITY, STATE, ZIP CODE	1 02/24/2016	
HERITAGE HALL - LAUREL MEADOWS				16600 DANVILLE PIKE LAUREL FORK, VA 24352		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLÉTIC	
	2 Continued From page 13 Section C (cognitive patterns) of the Residents admission (readmit) assessment with an ARD (assessment reference date) of 01/05/16 was coded with an 11 out of a possible 15 points. The clinical record included a physicians order signed and dated 12/31/16 for the lab tests CBC, BMP and magnesium in 1 week. The surveyor was unable to locate any results for these lab tests. The DON (director of nursing) was notified of the missing lab results on 02/23/16 at approximately 2:40 p.m. On 02/23/16 at approximately 4:40 p.m. during a meeting with the administrator, DON, ADON (assistant director of nursing), and nurse consultant the administrative staff were notified of the missing lab tests. No further information regarding this issue was provided to the survey team prior to the exit conference. 483.75(k)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS		Systemic Changes: The facility policy and procedure he been reviewed and no changes are warranted at this time. The laborate tracking system has been reviewed implemented to track and validate to required lab work has been comple per physician order and policy and procedure. The DON and/or Region Nurse Consultant will in-service all licensed staff on physician ordered laboratory-testing, protocols, & trace system used. Monitoring: The DON is responsible for maintain compliance. The DON and/or Unit Manager will complete the Facility audit tool weekly to monitor for compliance. Any negative findings where the protest of the attending physicial and disciplinary action will be taken warranted. The results of these audit will be reported to the Quality Assur Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.		changes are The laboratory on reviewed and ond validate that een completed policy and ond/or Regional on-service all can ordered pocols, & tracking for maintaining ond/or Unit the Facility Lab ontor for ore findings will ing physician of these audits outlings will on the saccolar of the saccolar of these audits outlings will on the saccolar of the	
	The facility must prov	ide or obtain radiology and				

F508

Corrective Action(s):

Resident #2's attending physician has been notified that resident #2 did not get a 2 view chest x-ray done as ordered by the physician. Only a 1 view AP chest xray was completed. A Facility Incident/Accident form has been completed for this incident.

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by:

other diagnostic services to meet the needs of its

residents. The facility is responsible for the

This REQUIREMENT is not met as evidenced

Based upon staff interview and clinical record

review, the facility staff failed to obtain a chest

quality and timeliness of the services.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES.

PRINTED: 03/04/2016 FORM APPROVED OMB NO 0938-0391

		NID 140. 0330-039			
1	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE (A BUILDING		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
partition and the same and the		495323	B WING		02/24/2016
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE	HALL - LAUREL M	EADOWS		16600 DANVILLE PIKE LAUREL FORK, VA 24352	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION

F 508 Continued From page 14

x-ray as ordered by the physician for 1 of 15 residents in the survey sample. (Resident #2) The findings included:

The facility staff failed to obtain a 2 view chest x-ray on Resident #2 as ordered by the physician. Resident #2 was readmitted to the facility on 9/9/15 with the following diagnoses of, but not limited to chronic shortness of breath, chest pain, congestive heart failure, depression, Parkinson's Disease and Rheumatoid Arthritis. Resident #2 MDS (Minimum Data Set, an assessment protocol) with an ARD (Assessment Reference Date) of 12/9/15 coded the resident was having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #2 was also coded as requiring extensive assistance with 2 staff members for personal hygiene and requiring total dependence on staff for bathing. During the clinical record review on 2/23/16, the following physician ordered was noted for 12/10/15: "1. Chest x-ray 2 view ... ". The results of this chest x-ray ordered for 12/10/15 was also noted in the clinical record. In the Radiology Report dated for 12/10/15 under examination it was documented "CHEST - 1 View AP "

On 2/23/16 at approximately 3:30 pm, the director of nursing was notified of the above documented findings. The director of nursing stated, "It was only done as 1 view instead of a 2 view chest x-ray".

No further information was provided to the surveyor prior to the exit conference on 2/24/16.

F 508

Identification of Deficient Practice(s) & Corrective Action(s):

All other residents with physician ordered x-rays and lab work may have potentially been affected. A 100% audit of resident clinical records for physician ordered laboratory work and x-rays will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. A Risk Management Incident & Accident form will be completed and proper notification made to the resident's attending physician.

Systemic Changes:

The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced on the policy and procedure for obtaining resident laboratory tests and x-rays as ordered with the appropriate pre-procedure preparation orders.

Monitoring:

The DON is responsible for maintaining compliance. The DON and/or Unit Manager will review all physician orders daily and as needed to ensure that physician ordered X-rays and lab work are being obtained and completed for residents as ordered by their attending physician. 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: April 8, 2016

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VDH/OLC