

Heritage Hall - Laurel Meadows Our Home, Our Family, Our Life, Too.

January 26, 2017

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

Mr. Cacciatore,

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 C. Darnell

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PRINTED: 01/23/2017 FORM APPROVED OMB NO. 0938-0391

ENTERS	S FOR MEDICARI	E & MEDICAID SERVICES				, 0930-0331
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F 000	INITIAL COMME	NTS	FO	000		
F 253 SS=0	survey was condo 1/12/17. Correct with 42 CFR Par requirements and for the Licensur Safety Code sur. The census in the time of the consisted of 16 (Residents 1 the reviews (Resident 4 th	EMENT is not met as evidenced ervation, and staff interview, the led to provide a clean and sanitary of 16 residents. Resident #4.	F F	F253 Corrective Action(s): Resident #4's Wheel Chair thoroughly cleaned. Identification of Deficient and Corrective Action(s): All other resident wheelch potentially been affected. documented environmenta facility wheelchairs will be the administrator, and/or e services director to identifi wheelchairs at risk. All resumble wheelchairs identified at releaned by the housekeep	t Practice(s) airs may have A complete I review of all c conducted by nvironmental y resident sident isk will be	

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

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

Event ID: 4C1H11

Facility ID: VA0105

If continuation sheet Page 1 of 14

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	& MEDICAID SERVICES					
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HALL - LAUREL N	IEADOWS		LAU			(X5)
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administration of further informations this time. 1 483.21(b)(3)(l) PROFESSION (b)(3) Comprel	staff prior to exit on 1/11/17. No tion was provided by the facility SERVICES PROVIDED MEET AL STANDARDS hensive Care Plans provided or arranged by the facility		F 28 ⁻	been notified that the facility sta administered Furosemide (Lasix physician order although the res an allergy to Furosemide. Resid- physician ordered Furosemide a allergy have been reviewed and by the attending physician to en medication orders and allergies) per ident had ent #1's nd the clarified sure all are Accident	
	SUMMARY ST. (EACH DEFICIENC REGULATORY OR PURCEUTE PROPERTY OR PURCEUTE PROPERTY OR PURCEUTE PROPERTY OR PURCEUTE PROPERTY OR THE WHOLE AND THE WHOLE AND THE WHOLE AND THE WHOLE AND THE PROPERTY OF THE ADMINISTRATION OF THE ADMINISTRATION OF THE ADMINISTRATION OF THE PROPERTY OF THE ADMINISTRATION OF THE AD	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 understood. Resident # 4 was observed on 1/10/17, sitting in her wheel chair (w/c). She was neat and clean. Her wheelchair (w/c) had particles of dried food on the wheels and the bars underneath were very dusty. The edges of the cushion she was sitting on had white stains covering it. Resident #4 also had on a seat belt that had food stains on it. The dirty w/c, cushion and seat belt was again noted on 1/11/17. On the morning of 1/11/17 the w/c was brought the attention of the activity CNA. The surveyor asked, "when were the w/c's cleaned." After looking at the w/c, she said, "I will find out whe they are cleaned." The CNA came back with the environmental services director who informed the surveyor that the w/c's were cleaned monthly. The regional nurse consultant was asked to look at the w/c and she said, "I will have them clear it." The aforementioned was discussed with the administration staff prior to exit on 1/11/17. No further information was provided by the facility this time. 483.21(b)(3)(l) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS (b)(3) Comprehensive Care Plans The services provided or arranged by the facility as outlined by the comprehensive care plan,	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 Inderstood. Resident # 4 was observed on 1/10/17, sitting in the wheel chair (w/c). She was neat and clean. Her wheelchair (w/c) had particles of dried food on the wheels and the bars underneath were very dusty. 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FORM CMS-2567(02-99) Previous Varsions Obsolete

Event ID: 4C1H11

Facility ID: VA0105

If continuation sheet Page 2 of 14

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

Event ID: 4C1H11

Facility ID: VA0105

If continuation sheet Page 3 of 14



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d " Medicativeyor on 1/10 ewed the ponis policy cordication to a ring this aller back to look litry goes by 4:45 pm, the ordinator proministering Nicy stated th "8. The	on and Treatment Orders " to to 10/17 at 4:30 pm. The surveyor licy and there was nothing listed neerning administration of a resident if they were listed as regy. The DON stated she would in the pharmacy policies that the also. MDS (Minimum Data Set) ovided a policy titled "Medications " to the surveyor. e following: following information must be	d he			
	SUMMARY STACH DEFICIENCE SULATORY OR I	A95323 OR SUPPLIER - LAUREL MEADOWS SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) AURED From page 3 IAR for the month of January, 2017 was wed by the surveyor. Resident #1 was histered "Lasix 20 mg 1 po am beginning orning of 1/5/17 and ending on 1/10/17". urveyor asked the director of nursing (DON access to the MAR for the January, 2017 esident #1. This occurred on 1/10/17 at eximately 3:30 pm. The DON went to her outer and gained access to the MAR that this are the allergies for (name of ent) Lasix was listed under the allergies for dent #1. No one caught this before they set to her. I will notify the physician and write medication incident right now. "The eyor asked the DON for a copy of the dards of nursing that the facility would use hold their nurses accountable for. The DON at the dards of nursing that the facility would use hold their nurses accountable for. The DON at the dards of nursing that the facility would use hold their nurses accountable for. The DON at the dards of nursing that the facility would use hold their nurses accountable for. The DON at the dards of nursing that the facility policy in this case. DON provided a copy of the facility policy at "Medication and Treatment Orders" to the reyor on 1/10/17 at 4:30 pm. The surveyor ewed the policy and there was nothing lister and instration of a dication to a resident if they were listed as a ling this allergy. The DON stated she would back to look in the pharmacy policies that the lifty goes by also. 4:45 pm, the MDS (Minimum Data Set) ordinator provided a policy titled "	Ap5323 JAR For the month of January, 2017 was ved by the surveyor. Resident #1 was vistered "Lasix 20 mg 1 po am beginning orning of 1/5/17 and ending on 1/10/17". urveyor asked the director of nursing (DON) access to the MAR for the January, 2017 exident #1. This occurred on 1/10/17 access to the MAR for the January, 2017 exident #1. This occurred on 1/10/17 access to the MAR for the January, 2017 exident #1. This occurred on 1/10/17 access to the MAR for the January, 2017 exident #1. This occurred on 1/10/17 at eximately 3:30 pm. The DON went to her outer and gained access to the MAR that this expor was asking for. The DON stated, "are the allergies for	OR SUPPLIER - LAUREL MEADOWS SUMMARY STATEMENT OF DEFICIENCIES CONTROLOGY MUST BE PRECEDED BY FULL SULATORY OR LSC IDENTIFYING INFORMATION) THE DON IS RESPONSIBLE FROM THE WAS instered "Lasix 20 mg 1 po am beginning orning of 1/5/17 and ending on 1/10/17 at carees to the MAR for the January, 2017 saident #1. This occurred on 1/10/17 at switch #1. This occurred on 1/10/17 at rate the allergies for ent) Lasix was listed under the a	OR SUPPLIER - LAUREL MEADOWS SITEET ADDRESS, CITY, STATE, ZIP CODE 16000 DANVILLE PIKE LAUREL FORK, VA 24352 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) AUREO From page 3 ANAR for the month of January, 2017 was used by the surveyor. Resident #1 was istered "Lasix 20 mg 1 po am beginning orning of 1/5/17 and ending on 1/10/17" at eximately 3:30 pm. The DON went to her uther and gained access to the MAR for the January, 2017 ascident #1. This occurred on 1/10/17 at eximately 3:30 pm. The DON went to her uther and gained access to the MAR hat this yery was asking for. The DON stated, " are the allergies for (name of enth 12 six was listed under the allergies for dent #1. No one caught this before they it to her, I will notify the physician and write medication incident right now." The every and advisory of the dards of nursing that the facility would use hold their nurses accountable for. The DON ad that she would get the policy the facility is in this case. DON provided a copy of the facility policy d "Medication and Treatment Orders" to the every on 1/10/17 at 4:30 pm. The surveyor even the policy and there was nothing listed is policy concerning administration of a dication to a resident if they were listed as ing this allergy. The DON stated she would back to look in the pharmacy policies that the lifty goes by also. 4:45 pm, the MDS (Minimum Data Set) ordinator provided a policy titled " ministering Medications " to the surveyor. The icy stated the following: "B. The following information must be exceked/verified for each resident prior to

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 01/11/2017		
		495323	B. WING				
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS			REET ADDRESS, CITY, STATE, ZIF 1600 DANVILLE PIKE AUREL FORK, VA 24352	CODE		
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F 281	a. Allergies to m b. Vital signs, if r On 1/11/17 at 9 ar if the policy docun standard of nursin DON stated, "Ye held accountable On 1/11/17 at 1 pr notified of the abo The surveyor call uses to obtain the This surveyor spo approximately 5 p Pharmacist #1 whad in their comp The pharmacist #1 "We have Lasix, Aldactone listed system." The s what the procedu order from a faci medication listed stated, "The ph speaks to a nurs have a true aller resident is truly a the nurse to call medication that looked in our co documentation i the facility to ask At 5 pm in the c	edication; and necessary " In, the surveyor asked the DON nented above would be the gractice for this facility. The state is what the nurses are for. " In, the administrative team was ove documented findings. In the administrative team was ove documented findings. In the pharmacy that the facility is medications for administered. One to Pharmacist #1 at one. The surveyor asked the nat were the allergies that they nate system for Resident #1. The surveyor asked the facility is eturned to the phone and state. Sulfa, Simvastatin, Codeine are for this resident in our compute urveyor asked the Pharmacist are was when they receive an lity and the resident has that as an allergy. Pharmacist #1 armacist calls the facility and to see if the resident does gy to the medication. If the an allergy, the pharmacist will a the doctor and get another the resident could take. I have mputer system and there is no in there about a pharmacist call is cabout this. " In onference room, the eam was notified of the above	d and r #1		If continuation		

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F 281 F 309 SS=D	from the facility pr 1/11/17. 483.24, 483.25(k)	ation was provided the surveyor ior to the exit conference on (I) PROVIDE CARE/SERVICES	F 281	Residents #1's attending ph notified that the facility fail administer Lasix as ordered	ed to I by the lity Medication		
	applies to all care residents. Each facility must provide to attain practicable physicomprehensive at 483.25 (k) Pain Manage The facility must provided to residents with pathe comprehens and the resident who reservices, consistent who residents who reservices, consistent who reservices, consistent who reservices, consistent who residents who reservices, consistent who reservices. This REQUIRE by: Based on staff review, the facility must be resident.	fundamental principle that and services provided to facility resident must receive and the ide the necessary care and or maintain the highest cal, mental, and psychosocial stent with the resident's assessment and plan of care. ment. ensure that pain management is lents who require such services, professional standards of practice ive person-centered care plan, so goals and preferences. facility must ensure that equire dialysis receive such tent with professional standards comprehensive person-centered he residents' goals and MENT is not met as evidenced interview and clinical record ity failed to follow physician's 16 residents. (Resident #1)	s e,	Identification of Deficient Practices/Corrective Acti All other residents may har potentially affected. The I Unit Manager will conduct of all resident's physician MAR's to identify residen Residents identified at risk corrected at time of discove comprehensive plans of careflect their resident speciattending physicians will each negative finding and Incident & Accident Form completed for each negative finding and Incident for each negative finding and Incident accident Form completed for each negative finding and Incident for each negative finding and Incident accident Form completed for each negative finding and Incident accident Form completed for each negative finding and Incident at this time. The assessment process as every 24 Hour Report and documedical record /physiciate the source document for and monitoring of the procedure for obtain and completing physiciate the procedure for obtain and completing physiciate the procedure for obtain and completing physiciate treatment orders.	on(s): we been DON and/or t a 100% audit orders and t at risk. c will be very and their are updated to fic needs. The be notified of a facility a will be ive finding. rocedures have visions are ne nursing idenced by the amentation in the n orders remains the development ovision of care, g, transcribing n orders, ment orders. The turse consultant d nursing staff of ing, transcribing,		

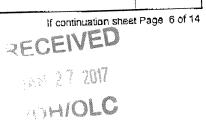
FORM CMS-2567(02-99) Previous Versions Obsolete

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Event ID: 4C1H11

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Facility ID: VA0105



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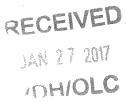
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TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495323	B. WING		Washington and the state of the	01/	11/2017
	E OF PROVIDER OR SUPPLIER RITAGE HALL - LAUREL MEADOWS			166	REET ADDRESS, CITY, STATE, ZIP CODE 500 DANVILLE PIKE JUREL FORK, VA 24352		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JD BE	(X6) COMPLETION DATE
F 309	Resident #1 was r 10/4/16 with the follimited to high blood dementia, anxiety Failure and Pulmo MDS (Minimum D (Assessment Reform Resident #1 was of long term memory impaired in decisive also coded as recommended in decisive also coded as recommended to assist the surveyor on 1 physician order ofLasix 20 mg (m) (every morning) asked registered above document in the Resident #1 Administration R go to (nare to the DON the about this to the director of to the DON the about the resident of 1 dose too many The surveyor as facilities policy could be provided 4:45 pm, the MI Coordinator gaven.	eadmitted to the facility on illowing diagnoses of, but not od pressure, diabetes, disorder, Congested Heart onary Fibrosis. On the quarterly ata Set) with an ARD erence Date) of 12/29/16, coded as having short term and y problems with being severely on making. The resident was quiring total dependence on 2 or ers for bathing and one staff with personal hygiene. Inical record was reviewed by /10/17. The surveyor noted a ated for the following: "1/4/17 hilligram) po (by mouth) q am ated for the following: "1/4/17 hilligram) po (by mouth) q am ated for the following: "1/4/17 hilligram) po (by mouth) q am ated for the following: "1/4/17 hilligram) po (by mouth) q am ated for the following: "1/4/17 hilligram) po (by mouth) q am ated for the following: "1/4/17 hilligram) po (by mouth) q am ated for the following: "1/4/17 hilligram) po (by mouth) q am ated for the following: The surveyor were nursing (DON), RN#1 verbalized above documented findings. The surveyor, "the order for Lasi and the nurses started giving the /5 and finished administrating the 1/10. The resident did received	of 3 lktdex.is	309	Monitoring: The DON will be responsible for maintaining compliance. The DON Unit Managers will perform weekl audits coinciding with the care placealendar to monitor for compliance Any/all negative findings and or ewill be corrected at time of discov disciplinary action will be taken as needed. Aggregate findings of the audits will be reported to the Qual Assurance Committee quarterly for review, analysis, and recommends for change in facility policy, procand/or practice. Completion Date: 02/25/2017	n e. rrors ery and s ese lity or ations	chart Page 7

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Event ID: 4C1H11

Facility ID: VA0105

If continuation sheet Page 7 of 14



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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COMP	LETED
		495323		Acontaction		01/1	1/2017
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	SE HALL - LAUREL N	MEADOWS			io danville pike IREL FORK, VA 24352		
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F 309	Continued From p Medications". The policy: "3. Medica accordance with the required time from On 1/11/17 at 1 p administrative teat findings. The administrative MAR concerning days instead of 5 the physician. No further inform surveyor prior to 483.45(a)(b)(1) F ACCURATE PRO (a) Procedures. pharmaceutical sthat assure the a dispensing, and biologicals) to m (b) Service Con- employ or obtain pharmacist who (1) Provides cor provision of pha	age 7 e following was noted in the stions must be administrated in the orders, including any me " In, the surveyor notified the team of the above documented the addings on Resident #1 's giving Lasix to the resident 6 days as it had been ordered by the exit conference on 1/11/17. PHARMACEUTICAL SVC - OCEDURES, RPH A facility must provide services (including procedures accurate acquiring, receiving, administering of all drugs and the services of a licensed the services of a licensed the services on all aspects of the armacy services in the facility;	F	309	F425 Corrective Action(s): Resident #2's attending physician been notified that the facility fail ensure that physician ordered me Fentanyl 25mcg/hr, Glucosaming Chondroitin were unavailable from pharmacy for administration to Fermal Page 18. A facility Incident and Accidents been completed for this incidents.	n has ed to edications e and om Resident	
	surveyor prior to 483.45(a)(b)(1) F ACCURATE PRO (a) Procedures, pharmaceutical sthat assure the adispensing, and biologicals) to m (b) Service Consemploy or obtain pharmacist who (1) Provides conprovision of pha This REQUIRES by: Based on staff review and clini	The exit conference on 1/11/17. PHARMACEUTICAL SVC - OCEDURES, RPH A facility must provide services (including procedures accurate acquiring, receiving, administering of all drugs and reet the needs of each resident. Sultation. The facility must in the services of a licensed insultation on all aspects of the		F 425	Corrective Action(s): Resident #2's attending physician been notified that the facility fail ensure that physician ordered me Fentanyl 25mcg/hr, Glucosamine Chondroitin were unavailable from pharmacy for administration to Ferman Hz. A facility Incident and Accident	ed to edications e and om Resident dent form	

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Event ID: 4C1H11

Facility ID: VA0105

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PRINTED: 01/23/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
w. CARO	JOHN CONTRACTOR	sould have the transfer of the sould be transfer on the sould be transfer or the sould be transf	A. BUILD				
		495323	B. WING		The second secon	01/1	11/2017
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
HEDITAC	E HALL - LAUREL N	EADOWS			DANVILLE PIKE		
ПЕКПАС	C HALL - LAUREL N	IEADOWS		LAU	REL FORK, VA 24352		D/F1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE	COMPLETION DATE
F 425	medication availate residents as order #2) The findings inclusively as 7/20/16 with the filimited to anemia anxiety disorder, fracture. The resident #2 was dependent on 1 spersonal hygiene Resident #2 clinically apply topically apply app	ple to administer to the ed by the physician. (Resident ded: readmitted to the facility on plowing diagnoses of, but not high blood pressure, diabetes, and arthritis and post hip ident was coded on the MDS let) with an ARD (Assessment of 10/11/16 as having short term memory deficits. also coded as being totally staff member for dressing, and bathing. Cal record was reviewed by the dered for Resident #2 to receive leg/hr (microgram per hour) patch (every) 3 days for pain and (and) Chondroitin Cap (capsule) blet) po (by mouth) BID (twice a ledication Administration Record vere also reviewed by the		425	Identification of Deficient Prace Corrective Action(s): All residents may have potential affected. A 100% review of all remedication regimes has been conby the DON and/ or Unit managidentify residents at risk. Reside to be at risk due the medications unavailable from the pharmacy corrected at time of discovery at attending physicians will be not facility Incident and Accident for been completed for each. Systemic Changes: The Pharmacy Policy and Procedure for medications admit to included medications that are unavailable or do not arrive at timely from the pharmacy for administration. The in-service include the steps the nurses should a medication not be del timely from the pharmacy. Monitoring: The DON is responsible for me compliance. The DON will correviews of resident medication.	lly been resident's inducted gers to ents found is being will be ind their tified. A form has edure has are g staff have and inistration the facility will ould take livered maintaining onduct in orders	
	surveyor. On 9/ was noted in the concerning the 9/9/2016 8:00 a the history com- the following do concerning the Chondroitin: " pm was not adr	9/16, the following documentation history comments of the MAR Fentanyl patch: "scheduled from was not administered" Of the October, 2016 MAR cumentation was noted administration of Glucosamine &scheduled for 10/21/2016 8:00 ministered" A physicians in and timed for 10/23/16 1100 a	for n R,	-	each week to confirm the avairall ordered drugs. All negative will be corrected at the time of Results of the reviews will be the Quality Assurance Commit review, analysis, and recomm for change in facility policy, prand/or practice. Completion Date: 02/25/201	e findings of discovery. reported to ittee for hendations procedure,	

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Event ID: 4C1H11

Facility ID: VA0105

If continuation sheet Page 9 of 14

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PRINTED: 01/23/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT (S POR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:		TIPLE CONS		(X3) DATE SURVEY COMPLETED		
		495323	B. WING				11/2017	
	ROVIDER OR SUPPLIER			16600 D	ADDRESS, CITY, STATE, ZIP CO ANVILLE PIKE L FORK, VA 24352	JUE		
(X4) ID PREFIX TAG	/EACH DESIGNED	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED 6Y FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 425	until arrives from noted documenta this date reflecting. On 1/11/17 at 1 p administrative tea documented findicopy of the policy were not available. The surveyor recument at 2:30 pm from policy stated the mediate within interim/stat/emedetermines that delivery is necessither: 2.1 With Pharm interim/stat/emedetermines that delivery is necessither: 2.2 For delivery 2.3 For the medelivered by a timely receipt mediated murses is shown administration DON stated this procedure.	ave Fentanyl 25 mcg/hr in place pharmacy. "The surveyor also tion in the nurses' notes for g the same. In the conference room, the am was notified of the above ings. The surveyor requested a regarding medications that e from pharmacy. Selved a copy of the policy titled rim/Stat/Emergency Deliveries "the director of nursing. The following: sessary medication is not the Facility's regency supply, and Facility an interim/stat/emergency ssary, Facility should arrange macy to include the ergency medication(s) in earliery or a special delivery, as y by contract courier, or, dication to be dispensed and Third Party Pharmacy to ensure." sked the director of nursing what to be available for the to the resident as scheduled. To the nurses' should have follow with the pharmacy."	et anyl he ed	425				
	The administration documented fi	ative staff was notified of the about notings again at 5 pm in the explored Event ID:			ity ID: VA0105	If continuation	sneet Page 10	

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				(X3) DATE	SUBVEY
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		495323	B. WING			01/	11/2017
	ROVIDER OR SUPPLIER E HALL - LAUREL N	1FADOWS	STREET ADDRESS, CITY, STATE, ZIP CO 16600 DANVILLE PIKE LAUREL FORK, VA 24352				
(X4) ID PREFIX TAG	SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_U 6E	(X5) COMPLETION DATE
F 425	Continued From p conference room No further informa surveyor prior to t 483.45(c)(1)(3)-(5) REPORT IRREG c) Drug Regimen (1) The drug regimenter of the drug	age 10 by the surveyor. ation was provided to the he exit conference on 1/11/17. b) DRUG REGIMEN REVIEW, ULAR, ACT ON	F 425		F428 Corrective Action(s): Resident #1 has been re-assessed by the attending physician and the consulting pharmacist for accurate allergies listed on the medical record and the pharmacy and the comprehensive care plans has been revised to reflect approaches and interventions to meet the resident's current medication needs. Identification of Deficient Practices & Corrective Action(s):		
	to the attending facility's medica and these report (i) Irregularities drug that meets (d) of this section (ii) Any irregula during this reviseparate, writte attending physicirector and director and d	ant;	g, any ph		All other residents may have been potentially affected. The pharmac consultant will conduct a 100% re all current residents medication re to identify any resident allergies, recommendations, follow up, and Any/all negative findings will be corrected at time of discovery. A Management Incident/Accident for each incident identification.	y view of gimens review. Risk orm will entified.	sheet Page 11

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Event ID: 4C1H11

Facility ID: VA0105

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& MEDICAID SERVICES				(VO) DAT	E QURVEY
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495323	B. WING		4534	01/	11/2017
MEADOWS	·	LA			O/E)
SY MUST BE PRECEDED BY FULL		1	JEACH CORRECTIVE ACTION SHOW	ルレ ロミ	COMPLETION DATE
page 11 by the pharmacist identified. If physician must document in that record that the identified sen reviewed and what, if any, taken to address it. If there is to the medication, the attending document his or her rationale is edical record. It is develop and maintain policifor the monthly drug regimen de, but are not limited to, time different steps in the process and racist must take when he or she gularity that requires urgent act sident. MENT is not met as evidenced interview, pharmacy interview a seview, the facility staff failed to ort medication irregularities for in the survey sample. (Resider cluded: As readmitted to the facility on the following diagnoses of, but no blood pressure, diabetes, ety disorder, Congested Heart Ilmonary Fibrosis. On the quart in Data Set) with an ARD Reference Date) of 12/29/16, as coded as having short term a crision making. The resident was resident resident was resident resident.	e es in the state of the state	428	Systemic Change(s): The facility Policy and Procedure I been reviewed and no changes are warranted at this time. The consult pharmacist will review all resident medication regime monthly to add appropriate use, allergies, reductic elimination if needed. All licensed nursing staff will be in-serviced by DON on the importance of review resident allergies when obtaining medication orders. The DON and Manager will review all pharmace recommendations monthly to ensury/all pharmacy recommendations attending physicians has been compliance. The DON, and/or dwill perform weekly audits of the medication orders coinciding with care plan calendar to maintain compliance. Any/all negative firelated to allergies will be correctime of discovery and disciplinataken as needed. Detail finding review will be reported to the Cassurance Committee for review analysis, and recommendations change in facility policy, proceeding and/or practice.	ant 's ress n, and l y the ring new /or Unit y ure that ons have cation to mpleted. ntaining esignee e th the ndings cted at ary action s of this Quality ww, s for dure,	
	MEADOWS MEA	MEADOWS MEA	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE OF A BUILDING	CX1 PROVIDERISUPPLIERICLIA LOENTIFICATION NUMBER: A BUILDING	(X2) MULTIPLE CONSTRUCTION A BULDING 495323 B. WING STREET ADDRESS, CITY, 8TATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPLOYING INFORMATION) PREFEX TAG Systemic Change(s): The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The consultant pharmacist will review all resident's medication, the attending document his or her rationale in addical record. The monthly drug regimen de, but are not limited to, time different steps in the process and tacist must take when he or she gularity that requires urgent action sident. MENT is not met as evidenced interview, pharmacy interview and existent unstrained in the facility on e effort the facility staff failed to ort medication irregularities for 1 in the survey sample. (Resident cluded: Bas readmitted to the facility on e blood pressure, diabetes, ety disorder, Congested Heart immonary Fibrosis. On the quarterly m Data Set) with an ARD Reference Date) of 12/29/16, as coded as having short term and mory problems with being severely cision making. The resident was requiring total dependence on 2 or A BULDING STREET ADDRESS, CITY, 8TATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CRECH CORRECTIVE ACTION (EACH CORRECTIVE ACTION SHOULD BE CRECH CORRECTION (EACH CORRECT (EACH CORRECT (EACH CORRECT (EACH COR

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Facility ID: VA0105



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TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED	
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AME OF PROVIDER OR SUPPLIER IERITAGE HALL - LAUREL MEADOWS		STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF COR IX (EACH CORRECTIVE ACTION	SHOULD BE	(X6) COMPLETION DATE
F 428	Resident #1 's clithe surveyor on 1/surveyor that Resmedication allergy face sheet, MAR Record) and dischospital in the clir physician order w (milligram) 1 po (IX (times) 5 days. an area at the top allergies to be list area was left blar allergies listed. Inoted "by a nurs faxed to the pharman The MAR for the reviewed by the redministered "Lambda administered "Lambda accession of 1. The surveyor as if she could accession at approximately computer and gasurveyor was as Here are the alleresident) Lasix was Resident #1. No gave it to her. In up a medication	with personal hygiene. nical record was reviewed by (10/17. It was noted by the ident #1 was listed as having a of Furosemide (Lasix) on the (Medication Administration harge summary from the nical record. On 1/4/17, a as noted for "Lasix 20 mg by mouth) q am (every morning). The physician order sheet had of the page for medication ted. The surveyor noted that the hk. There was no medication he above physician order was see on 1/4/17 and the order was	N)	428		

FORM CMS-2567(02-99) Previous Versions Obsolute Event ID: 4C1H11

Facility ID: VA0105

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JAN 27 2017

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495323	B. WING			01/	11/2017	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEPICIENCY)	D BE	(X5) COMPLETION DATE	
F 428	was performed by was no document concerning the reand the staff adm resident. The surveyor calluses to obtain the had listed for Resand spoke to Phapm on 1/11/17. Tharmacist what documented in the Resident #1. The phone and stated Simvastatin, Cooresident in our coasked Pharmacist when they receive resident has that Pharmacist #1 sfacility and spearesident does have medication. If the pharmacist will a and get another could take. I had and there is no opharmacist calling the could take and the could take. I had and there is no opharmacist calling the could take and the could take. I had and there is no opharmacist calling the could take and the could take. I had and there is no opharmacist calling the could take and the could take and the could take. I had and there is no opharmacist calling the could take and the could take and the could take and there is no opharmacist calling the could take and take and the could take and the could take and take and the could take and t	noted that a pharmacy review a pharmacist on 1/5/17. There ation in the pharmacy review sident being allergic to Lasix inistering this medication to the ed the pharmacy that the facility allergies that the pharmacy sident #1. This surveyor called armacist #1 at approximately 5 he surveyor asked the were the allergies that were elir computer system for a pharmacist returned to the elir computer system for a pharmacist returned to the elir computer system. The surveyor at #1 what the procedure was be an order from a facility and the medication listed as an allergy. It was to a nurse to see if the elie resident is truly an allergy, the elie resident is truly an allergy, the elie resident is truly an allergy, the elie has the nurse to call the doctor medication that the resident we looked in our computer system and the facility to ask about this. I conference room, the earn was notified of the above	s r e e	428				

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Facility ID: VA0105

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COMMONWEALTH of VIRGINIA

Department of Health

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

Office of Licensure and Certification

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

January 23, 2017

Mr. Wrightly Darnell, Administrator Heritage Hall - Laurel Meadows 16600 Danville Pike Laurel Fork, VA 24352

RE:

Heritage Hall - Laurel Meadows

Provider Number 495323

Dear Mr. Darnell:

An unannounced standard survey, ending January 11, 2017, was conducted at your facility by staff from the Virginia Department of Health's Office of Licensure and Certification (the State Survey Agency) to determine if your facility was in compliance with Federal long term care participation requirements for the Medicare and/or Medicaid programs and, if applicable, State licensure regulations. No complaints were investigated during the survey.

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

Survey Results

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

0845010R (664) 361-2102 ACUTE CARE

COP11 (804) 187-2128 VD PYREGINA
DEPARTMENT
OF INLATE
PROPERTY OF INLATE

COMPLAINTS

LONG TEHM CART (804) NGT-2100 Mr. Wrightly Darnell, January 23, 2017 Page 2

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

Plan of Correction (PoC)

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

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

To be considered acceptable, the PoC must:

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

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

Informal Dispute Resolution

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

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

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

Recommended Remedies

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

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

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

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

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

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Survey Response Form

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

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

Sinceredy

Elaine Cacciatore, LTC Supervisor Division of Long Term Care

Enclosure

CC:

Joani Latimer, State Ombudsman

Joann Atkins, Dmas (Sent Electronically)

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