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 C. Darnell

Wrightly Darnell
Administrator

RECEIVED
JAN 27 2017
VDH/OLC

16600 Danville Pike / Laurel Fork, Virginia 24352 / 276 398-2117 / Fax 276 398-3122
HEALTHCARE AND REHABILITATION CENTER
Managed by AMERICAN HEALTHCARE, LLC

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - LAUREL MEADOWS	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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 01/10/17 through 01/11/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 13) and 3 closed record reviews (Residents 14 through 16).	F 000		
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. Maintenance and Housekeeping 12 VAC 5-371-370 (G)- Cross reference to F253 Nursing Services 12 VAC 5-371-220 (B)-Cross reference to F281 and F309 Pharmaceutical Services 12 VAC 5-371-300 (A and H)-Cross reference to F425 and F428	F 001	**F001** **Maintenance and Housekeeping** **12 VAC 5-371-370 (G) - Cross reference to F-253** Cross Reference POC for F-253 **Nursing Services** **12 VAC 5-371-220 (B) Cross reference to F-281 and F-309** Cross Reference POC for F-281 and F-309 **Pharmaceutical Services** **12 VAC 5-371-300 (A and H) Cross reference to F-425 and F-428** Cross Reference POC for F-425 and F-428 **Completion Date**: 02/25/2017	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Wrightley C. Darnell | Administrator | 1-25-2017

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 01/10/17 through 01/12/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 1 through 13) and 3 closed record reviews (Residents 14 through 16).	F 000		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview, the facility staff failed to provide a clean and sanitary wheel chair for 1 of 16 residents. Resident #4. The findings include: Resident #4 was admitted to the facility on 9/8/14. Her diagnoses included, but were not limited to; dementia, low back pain, spinal stenosis, and dysphagia. Resident #4 ' s MDS (minimum data set) assessment, with an ARD (assessment reference date) of 11/2/16, was reviewed. She has short term and long term memory and decision making deficits. She usually understands and is usually	F 253	**F253** **Corrective Action(s):** Resident #4's Wheel Chair has been thoroughly cleaned. **Identification of Deficient Practice(s) and Corrective Action(s):** All other resident wheelchairs may have potentially been affected. A complete documented environmental review of all facility wheelchairs will be conducted by the administrator, and/or environmental services director to identify resident wheelchairs at risk. All resident wheelchairs identified at risk will be cleaned by the housekeeping department.	

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F 253	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 to 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 when 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 clean it. " The aforementioned was discussed with the administration staff prior to exit on 1/11/17. No further information was provided by the facility at this time.	F 253	**Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director and/or Environmental Director will provide inservices to all staff on facility policy and procedure on the notification system to use when cleaning and repairs are needed throughout the facility. **Monitoring:** The Environmental Director and the administrator are responsible for maintaining compliance. Documented wheelchair rounds will be completed weekly to monitor compliance. The administrator will review the wheelchair audits weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date:** 02/25/2017	
F 281 SS=D	483.21(b)(3)(i) 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, must- (i) Meet professional standards of quality.	F 281	**F281** **Corrective Action(s):** Resident #1's attending physician has been notified that the facility staff administered Furosemide (Lasix) per physician order although the resident had an allergy to Furosemide. Resident #1's physician ordered Furosemide and the allergy have been reviewed and clarified by the attending physician to ensure all medication orders and allergies are accurate. A Facility Incident & Accident Form was completed for these incidents.	

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F 281	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of nursing practice for 1 of 16 residents. (Resident #1) The findings included: Resident #1 was readmitted to the facility on 10/4/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, anxiety disorder, Congested Heart Failure and Pulmonary Fibrosis. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/29/16, Resident #1 was coded as having short term and long term memory problems with being severely impaired in decision making. The resident was also coded as requiring total dependence on 2 or more staff members for bathing and one staff member to assist with personal hygiene. Resident #1 ' s clinical record was reviewed by the surveyor on 1/10/17. It was noted by the surveyor that Resident #1 was listed as having a medication allergy of Furosemide (Lasix) on the face sheet, MAR (Medication Administration Record) and discharge summary from the hospital in the clinical record. On 1/4/17, a physician order was noted for " ...Lasix 20 mg (milligram) 1 po (by mouth) q am (every morning) X (times) 5 days. The physician order sheet had an area at the top of the page for medication allergies to be listed. The surveyor noted that this area was left blank. There was no medication allergies listed. The above physician order was " noted " by a nurse on 1/4/17 and the order was faxed to the pharmacy.	F 281	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON or Unit Manager will conduct a 100% review of all resident's medication orders to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include checking and verifying resident allergies prior administration of a medication and the required MD notification.	

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F 281	Continued From page 3 The MAR for the month of January, 2017 was reviewed by the surveyor. Resident #1 was administered " Lasix 20 mg 1 po am beginning the morning of 1/5/17 and ending on 1/10/17 ". The surveyor asked the director of nursing (DON) if she access to the MAR for the January, 2017 for Resident #1. This occurred on 1/10/17 at approximately 3:30 pm. The DON went to her computer and gained access to the MAR that this surveyor was asking for. The DON stated, " Here are the allergies for _____ (name of resident) Lasix was listed under the allergies for Resident #1. No one caught this before they gave it to her. I will notify the physician and write up a medication incident right now. " The surveyor asked the DON for a copy of the standards of nursing that the facility would use and hold their nurses accountable for. The DON stated that she would get the policy the facility uses in this case. The DON provided a copy of the facility policy titled " Medication and Treatment Orders " to the surveyor on 1/10/17 at 4:30 pm. The surveyor reviewed the policy and there was nothing listed in this policy concerning administration of a medication to a resident if they were listed as having this allergy. The DON stated she would go back to look in the pharmacy policies that the facility goes by also. At 4:45 pm, the MDS (Minimum Data Set) Coordinator provided a policy titled " Administering Medications " to the surveyor. The policy stated the following: " ...8. The following information must be checked/verified for each resident prior to administering medications:	F 281	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or Unit Manager will review medication orders weekly coinciding with the care plan calendar in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action 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:** 02/25/2017	

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F 281	Continued From page 4 a. Allergies to medication ; and b. Vital signs, if necessary ... " On 1/11/17 at 9 am, the surveyor asked the DON if the policy documented above would be the standard of nursing practice for this facility. The DON stated, " Yes, this is what the nurses are held accountable for. " On 1/11/17 at 1 pm, the administrative team was notified of the above documented findings. The surveyor called the pharmacy that the facility uses to obtain the medications for administered. This surveyor spoke to Pharmacist #1 at approximately 5 pm. The surveyor asked the Pharmacist #1 what were the allergies that they had in their computer system for Resident #1. The pharmacist returned to the phone and stated " We have Lasix, Sulfa, Simvastatin, Codeine and Aldactone listed for this resident in our computer system. " The surveyor asked the Pharmacist #1 what the procedure was when they receive an order from a facility and the resident has that medication listed as an allergy. Pharmacist #1 stated, " The pharmacist calls the facility and speaks to a nurse to see if the resident does have a true allergy to the medication. If the resident is truly an allergy, the pharmacist will ask the nurse to call the doctor and get another medication that the resident could take. I have looked in our computer system and there is no documentation in there about a pharmacist calling the facility to ask about this. " At 5 pm in the conference room, the administrative team was notified of the above documented findings.	F 281		

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F 281	Continued From page 5 No further information was provided the surveyor from the facility prior to the exit conference on 1/11/17.	F 281	**F309** **Corrective Action(s):** Residents #1's attending physician was notified that the facility failed to administer Lasix as ordered by the attending physician. A facility Medication Error form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON and/or 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. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility failed to follow physician ' s orders for 1 of 16 residents. (Resident #1) The findings included:	F 309		

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F 309	Continued From page 6 Resident #1 was readmitted to the facility on 10/4/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, anxiety disorder, Congested Heart Failure and Pulmonary Fibrosis. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/29/16, Resident #1 was coded as having short term and long term memory problems with being severely impaired in decision making. The resident was also coded as requiring total dependence on 2 or more staff members for bathing and one staff member to assist with personal hygiene. Resident #1 ' s clinical record was reviewed by the surveyor on 1/10/17. The surveyor noted a physician order dated for the following: " 1/4/17 ...Lasix 20 mg (milligram) po (by mouth) q am (every morning) x (times) 5 days. " The surveyor asked registered nurse (RN) #1 to look over the above documented physician order and compare it to Resident #1 ' s MAR (Medication Administration Record). RN #1 stated " Let me go to _____ (name of director of nursing) and talk to her about this. " RN #1 and the surveyor went to the director of nursing (DON), RN#1 verbalized to the DON the above documented findings. The DON stated to the surveyor, " the order for Lasix was for 5 days and the nurses started giving the medication on 1/5 and finished administrating this to the resident on 1/10. The resident did receive 1 dose too many. " The surveyor asked the DON if a copy of the facilities ' policy on administrating medications could be provided to the surveyor. On 1/10/17 at 4:45 pm, the MDS (Minimum Data Set) Coordinator gave the surveyor a copy of the facilities ' policy titled " Administrating	F 309	**Monitoring:** The DON will be responsible for maintaining compliance. The DON and/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar 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:** 02/25/2017	

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F 309	Continued From page 7 Medications". The following was noted in the policy: "...3. Medications must be administrated in accordance with the orders, including any required time frame ..." On 1/11/17 at 1 pm, the surveyor notified the administrative team of the above documented findings. The administrative team was again notified of the above documented findings on Resident #1 ' s MAR concerning giving Lasix to the resident 6 days instead of 5 days as it had been ordered by the physician. No further information was provided to the surveyor prior to the exit conference on 1/11/17.	F 309		
F 425 SS=E	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review and clinical record review, the facility staff failed to ensure that1of 16 residents had	F 425	**F425** **Corrective Action(s):** Resident #2's attending physician has been notified that the facility failed to ensure that physician ordered medications Fentanyl 25mcg/hr, Glucosamine and Chondroitin were unavailable from pharmacy for administration to Resident #2. A facility Incident and Accident form has been completed for this incident.	

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F 425	Continued From page 8 medication available to administer to the residents as ordered by the physician. (Resident #2) The findings included: Resident #2 was readmitted to the facility on 7/20/16 with the following diagnoses of, but not limited to anemia, high blood pressure, diabetes, anxiety disorder, and arthritis and post hip fracture. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date of 10/11/16 as having short term memory and long term memory deficits. Resident #2 was also coded as being totally dependent on 1 staff member for dressing, personal hygiene and bathing. Resident #2 clinical record was reviewed by the surveyor on 1/10/17. It was noted that the physician had ordered for Resident #2 to receive " Fentanyl 25 mcg/hr (microgram per hour) patch apply topically Q (every) 3 days for pain and Glucosamine & (and) Chondroitin Cap (capsule) Give one tab (tablet) po (by mouth) BID (twice a day). " " The MAR ' s (Medication Administration Record) of the resident were also reviewed by the surveyor. On 9/9/16, the following documentation was noted in the history comments of the MAR concerning the Fentanyl patch: " ...scheduled for 9/9/2016 8:00 am was not administered ... " On the history comments of the October, 2016 MAR, the following documentation was noted concerning the administration of Glucosamine & Chondroitin: " ...scheduled for 10/21/2016 8:00 pm was not administered ... " A physicians ' order was dated and timed for 10/23/16 1100 am	F 425	**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication regimes has been conducted by the DON and/ or Unit managers to identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each. **Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been in-serviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The in-service will include the steps the nurses should take should a medication not be delivered timely from the pharmacy. **Monitoring:** The DON is responsible for maintaining compliance. The DON will conduct reviews of resident medication orders each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 02/25/2017	

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(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 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 9 which stated " Leave Fentanyl 25 mcg/hr in place until arrives from pharmacy. " The surveyor also noted documentation in the nurses ' notes for this date reflecting the same. On 1/11/17 at 1 pm in the conference room, the administrative team was notified of the above documented findings. The surveyor requested a copy of the policy regarding medications that were not available from pharmacy. The surveyor received a copy of the policy titled " ...Receipt of Interim/Stat/Emergency Deliveries " at 2:30 pm from the director of nursing. The policy stated the following: ...2. If a necessary medication is not contained within the Facility ' s interim/stat/emergency supply, and Facility determines that an interim/stat/emergency delivery is necessary, Facility should arrange either: 2.1 With Pharmacy to include the interim/stat/emergency medication(s) in 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 ... " The surveyor asked the director of nursing what the nurses ' should have done when the Fentanyl was noted not to be available for the administration to the resident as scheduled. The DON stated " the nurses ' should have followed this procedure with the pharmacy. " The administrative staff was notified of the above documented findings again at 5 pm in the	F 425		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495323	A. BUILDING _____ B. WING _____	01/11/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - LAUREL MEADOWS	16600 DANVILLE PIKE LAUREL FORK, VA 24352

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F 425	Continued From page 10 conference room by the surveyor. No further information was provided to the surveyor prior to the exit conference on 1/11/17.	F 425		
F 428 SS=D	483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug,	F 428	**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):** All other residents may have been potentially affected. The pharmacy consultant will conduct a 100% review of all current residents medication regimens to identify any resident allergies, recommendations, follow up, and review. Any/all negative findings will be corrected at time of discovery. A Risk Management Incident/Accident form will be completed for each incident identified.	

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F 428	Continued From page 11 and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. (5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, pharmacy interview and clinical record review, the facility staff failed to identify and report medication irregularities for 1 of 16 residents in the survey sample. (Resident #1) The findings included: Resident #1 was readmitted to the facility on 10/4/16 with the following diagnoses of, but not limited to high blood pressure, diabetes, dementia, anxiety disorder, Congested Heart Failure and Pulmonary Fibrosis. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 12/29/16, Resident #1 was coded as having short term and long term memory problems with being severely impaired in decision making. The resident was also coded as requiring total dependence on 2 or more staff members for bathing and one staff	F 428	**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 regime monthly to address appropriate use, allergies, reduction, and elimination if needed. All licensed nursing staff will be in-serviced by the DON on the importance of reviewing resident allergies when obtaining new medication orders. The DON and/or Unit Manager will review all pharmacy recommendations monthly to ensure that any/all pharmacy recommendations have been addressed and proper notification to attending physicians has been completed. **Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will perform weekly audits of the medication orders coinciding with the care plan calendar to maintain compliance. Any/all negative findings related to allergies will be corrected at time of discovery and disciplinary action taken as needed. Detail findings of this review will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 02/25/2017	

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

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F 428	Continued From page 12 member to assist with personal hygiene. Resident #1 ' s clinical record was reviewed by the surveyor on 1/10/17. It was noted by the surveyor that Resident #1 was listed as having a medication allergy of Furosemide (Lasix) on the face sheet, MAR (Medication Administration Record) and discharge summary from the hospital in the clinical record. On 1/4/17, a physician order was noted for " ...Lasix 20 mg (milligram) 1 po (by mouth) q am (every morning) X (times) 5 days. The physician order sheet had an area at the top of the page for medication allergies to be listed. The surveyor noted that this area was left blank. There was no medication allergies listed. The above physician order was " noted " by a nurse on 1/4/17 and the order was faxed to the pharmacy. The MAR for the month of January, 2017 was reviewed by the surveyor. Resident #1 was administered " Lasix 20 mg 1 po am beginning the morning of 1/5/17 and ending on 1/10/17 ". The surveyor asked the director of nursing (DON) if she could access the MAR for the January, 2017 for Resident #1. This occurred on 1/10/17 at approximately 3:30 pm. The DON went to her computer and gained access to the MAR that this surveyor was asking for. The DON stated, " Here are the allergies for _____ (name of resident) Lasix was listed under the allergies for Resident #1. No one caught this before they gave it to her. I will notify the physician and write up a medication incident right now. " On 1/11/17 at 1 pm, the administrative team was notified of the above documented findings.	F 428		

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F 428	Continued From page 13 The surveyor also noted that a pharmacy review was performed by a pharmacist on 1/5/17. There was no documentation in the pharmacy review concerning the resident being allergic to Lasix and the staff administering this medication to the resident. The surveyor called the pharmacy that the facility uses to obtain the allergies that the pharmacy had listed for Resident #1. This surveyor called and spoke to Pharmacist #1 at approximately 5 pm on 1/11/17. The surveyor asked the Pharmacist what were the allergies that were documented in their computer system for Resident #1. The pharmacist returned to the phone and stated " We have Lasix, Sulfa, Simvastatin, Codeine and Aldactone listed for this resident in our computer system. " The surveyor asked Pharmacist #1 what the procedure was when they receive an order from a facility and the resident has that medication listed as an allergy. Pharmacist #1 stated, " The pharmacist calls the facility and speaks to a nurse to see if the resident does have a true allergy to the medication. If the resident is truly an allergy, the pharmacist will ask the nurse to call the doctor and get another medication that the resident could take. I have looked in our computer system and there is no documentation in there about a pharmacist calling the facility to ask about this. " At 5 pm in the conference room, the administrative team was notified of the above documented findings. No further information was provided the surveyor from the facility prior to the exit conference on 1/11/17.	F 428		

COMMONWEALTH of VIRGINIA

Department of Health

Office of Licensure and Certification

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

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.

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 the Office's Informal Dispute Resolution Process, which may be accessed at "http://www.vdh.state.va.us/OLC/longtermcare/".

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

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

Recommended Remedies

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

- Pursuant to §488.408(c)
  - Directed Plan of Correction (PoC) (§488.424).
  - State monitoring (§488.422).
  - Directed In-Service Training (§488.425).

- Pursuant to §488.408(d)
  - Denial of payment for new admissions - (§488.417).
  - Denial of payment for all individuals - (§488.418).
  - Civil Money Penalty, $50 - $3,000 per day (§488.430, §488.438), effective on the survey ending date,

- Civil money penalties of $1,000 - $10,000 per instance of noncompliance.

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

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

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

Survey Response Form

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

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

Sincerely,

Elaine Cacciatore, LTC Supervisor
Division of Long Term Care

Enclosure

cc: Joani Latimer, State Ombudsman
Joann Atkins, Dmas (Sent Electronically)