PRINTED: 04/26/2018 FORM APPROVED
OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495261  NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL NRSG AND REHAB  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  122 MORVEN PARK ROAD NW  LEESBURG, VA 20176  ID PROVIDER'S PLAN OF CORRE  PREFIX (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE APP  DEFICIENCY)	CTION (X5) OULD BE COMPLETION
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL NRSG AND REHAB  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	STREET ADDRESS, CITY, STATE, ZIP CODE  122 MORVEN PARK ROAD NW  LEESBURG, VA 20176  ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP	CTION (X5) OULD BE COMPLETION
HERITAGE HALL NRSG AND REHAB  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	122 MORVEN PARK ROAD NW LEESBURG, VA 20176  ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP	CTION (X5) OULD BE COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP	OULD BE COMPLÉTION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	!	
E 000 Initial Comments	E 000	
An unannounced Emergency Preparedness survey was conducted 4/17/18 through 4/19/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) was/were investigated during the survey.  F 000 INITIAL COMMENTS	F 000	
An unannounced Medicare/Medicaid standard survey was conducted 4/17/18 through 4/19/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.  The census in this 164 certified bed facility was 139 at the time of the survey. The survey sample consisted of 30 current residents reviews (Residents # 9, 335, 124, 1, 62, 6, 42, 88, 10, 64, 91, 112, 52, 57, 84, 102, 65, 22, 83, 95, 2, 334, 130, 78, 77, 336, 110, 23, 36, and 29) and three closed record reviews (Residents #133, 134, and 135).  F 622 Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii)  §483.15(c) Transfer and discharge-§483.15(c)(1) Facility requirements-(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless-	F622 Corrective Action(s): The facility staff failed to required documentation, a directives and comprehen goals were submitted to the hospital for Residents #64 #134. A facility Incident	advance sive care plan ne receiving 1, #110 and
(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the	Form has been completed resident involved.	for each

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

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RECEIVE Continuation sheet Page 1 of 53 Facility ID: VA0115

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				NAR MO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION		E SURVEY PLETED
		495261	B. WING			04/	19/2018
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
UEDITAC	T HALL MOCO AND	DELLAD		1	122 MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND	KENAB		L	LEESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT 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 APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	endangered due to status of the reside (D) The health of ir otherwise be endar (E) The resident has appropriate notice, under Medicare or Nonpayment applie submit the necessary payment or after the Medicare or Medicare in the Medicare or Medicare or Medicare or Medicare or Medicare in the Medicare or Medicare	by the facility; dividuals in the facility is the clinical or behavioral nt; adividuals in the facility would negered; as failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. It is if the resident does not ary paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a mes eligible for Medicaid after lity, the facility may charge a able charges under Medicaid; as to operate. In transfer or discharge the appeal is pending, pursuant to papeal is pending, pursuant to papeal is pending, pursuant to proper to a transfer or on the facility pursuant to get would endanger the health ident or other individuals in the must document the danger fer or discharge would pose. In ansfers or discharges a of the circumstances specified (i)(A) through (F) of this must ensure that the transfer umented in the resident's		622	Practices/Corrective Action(s): All other residents discharged and transferred from the facility may been affected. The DON/designe conduct a 100% audit of all reside have been discharged and/or transfrom the facility in the past 30 day identify residents that did not have required documentation submitted receiving facility. A facility Incid Accident Form will be completed negative finding.  Systemic Change(s): Facility policy and procedures has reviewed. No revisions are warrathis time. The DON and/or Region Nurse Consultant will inservice falicensed staff on the documentation required to be submitted to the refacility when a resident is being transferred or discharged to the hoother outside health care facility.  Monitoring: The DON/designee will be responsimatianing compliance. The DO designee will conduct chart audits of all residents who have been distand/or transferred from the facility monitor for compliance. Any/all findings and or errors will be contime of discovery. Aggregate find these audits will be reported to the Quality Assurance Committee que for review, analysis, and recommendations for change in fapolicy, procedure, and/or practice.	nave e will ents who efferred ys to e the d to the ent & for each  we been ented at onal acility on ceiving ospital or  nsible for N and/or s weekly scharged y to negative rected at lings of e arterly acility energian	
	When the facility transident under any in paragraphs (c)(1 section, the facility or discharge is documedical record and	ansfers or discharges a of the circumstances specified )(i)(A) through (F) of this must ensure that the transfer			findings and or errors will be contime of discovery. Aggregate find these audits will be reported to the Quality Assurance Committee que for review, analysis, and recommendations for change in fi	rected at lings of e arterly acility	

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communicated to the receiving health care

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
	495261	B. WING		04/19/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND RE	HAB ·	·	STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE COMPLETION
must include:  (A) The basis for the to (i) of this section.  (B) In the case of parasection, the specific researching the section, the specific researching to meet the needs, and the service facility to meet the need (ii) The documentation (2)(i) of this section moderated in the section moderated in the section of (A) The resident's physician when the section of (B) A physician when the necessary under parasethis section.  (iii) Information provide must include a minimum (A) Contact information responsible for the care (B) Resident represent contact information (C) Advance Directive (D) All special instruction ongoing care, as approved (E) Comprehensive care (F) All other necessaric copy of the resident's consistent with §483.2 any other documentation a safe and effective transportation on staff interviews.	the resident's medical record ransfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this esident need(s) that cannot its to meet the resident e available at the receiving ed(s). In required by paragraph (c) ust be made bysician when transfer or y under paragraph (c) (1) on; and transfer or discharge is graph (c)(1)(i)(C) or (D) of ed to the receiving provider um of the following: In of the practitioner re of the resident. Intative information including information ions or precautions for opriate. The plan goals; by information, including a discharge summary, and (c)(2) as applicable, and ion, as applicable, to ensure ansition of care. It is not met as evidenced etw., facility document review iew, it was determined that to ensure all required	F 62	2	

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STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING		04/19/2018
NAME OF PROVIDER OF		REHAB		STREET ADDRESS, CITY, STATE, ZIP C 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI  X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE COMPLÉTION
sample, F  1. The fact all require directives was provided and require care plan when Resident all require care plan when Resident all require care plan when Resident all require directives was provided and require directives was provided and resident	or three of Residents of Reside	f 33 residents in the survey #110, #64 and #134.  Failed to provide evidence that tion (including advance prehensive care plan goals) to hospital staff when Resident ed to the hospital on 3/11/18.  Failed to provide evidence that tion (including comprehensive as provided to the hospital staff was transferred to the 8 and 02/05/18.  Failed to provide evidence that tion (including comprehensive as provided to the hospital staff 4 was transferred to the	F 6		
major dep communic #110's mo 30 day Me (assessm the reside	ressive d cation def est recent edicare as ent refere nt's cogni	isorder, cognitive icit and pneumonia. Resident MDS (minimum data set), a esessment with an ARD ence date) of 4/11/18, coded tive skills for daily moderately impaired.			

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>)MB NO.</u>	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION		E SURVEY IPLETED
		495261	B. WING			04/	19/2018
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
HEDITAC	T HALL NDCC AND	DELIAD		122 1	MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND	KENAD		LEE	SBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	Continued From pa	ge 4	F	622			
	revealed a nurse's 2000H (8:00 p.m.) if from his (sic), this if and him (sic) starte and tried to hit to (sobserved combative. This nurse informed nursing) and MD (m.T.O. (telephone ord (emergency room) (treatment). POA (land left message to Further review of Refailed to reveal door information that was when Resident #110 On 4/18/18 at 2:26 conducted with LPN LPN #1 was asked resident is transferr stated, "We get all the call the doctor to let going out, make sur resident all the time give report so they lasked to explain the to the hospital, LPN the reason we send changes in the past treat the resident." medication administ doctor notes and a contract the resident and in the send contract the resident."	thin the paperwork set up, call back."  esident #110's clinical record walking out the resident of the page the page to the pa					
	When asked if a res	sident's care plan goals are					1

provided to the hospital staff, LPN #1 stated they

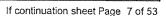
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILI	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495261	B. WING		04/19/2018
HERITAG (X4) ID		REHAB TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID	STREET ADDRESS, CITY, STATE, ZIP CODE  122 MORVEN PARK ROAD NW  LEESBURG, VA 20176  PROVIDER'S PLAN OF CORRECT	E CTION (X5)
PREFIX :		SC IDENTIFYING INFORMATION)	PREF TAG		
	information provide stated, "We do nurs we say paperwork i number in case the On 4/18/18 at 5:10 staff member) #1 (t (the director of nurs above findings.  On 4/19/18 at 7:15 facility conference r (along with other reform was a checklis "(Name of facility) PLACE ALL INFOR TRANSFER Face Sheet Current Medication administration recor Change in Cond Notes DNR (Do not res Most Recent His Recent MD/NP/F practitioner/physicial Orders Relevant X-Rays Results Copy of MD order POA/RP (Power Notification Verbal Report to Res. (Resident) Bas	ed how staff evidences the d to the hospital staff, LPN #1 ses notes. Most of the time included and include our y need anything extra."  p.m., ASM (administrative he administrator) and ASM #2 sing) were made aware of the a.m. (upon entrance into the oom), a form was on the table quested documents). The state that documented,  MATION IN ENVELOPE FOR stration record/treatment and between the conditions MD/Nurse Progress auscitate)/ Code Status tory and Physical PA (medical doctor/nurse in assistant) and Specialist and other Diagnostic Test	F	522	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495261	B. WING		04	/19/2018	
	PROVIDER OR SUPPLIER  BE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LEESBURG, VA 20176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION DATE	
F 622	explain the above fracility staff has a grospital. ASM #2 staff what they wan them (when a residitems on the list are hospital staff. ASM calls the hospital staff. ASM calls the hospital to sometimes goes to resident until family provide evidence of provided to hospital was transferred to the she could call the hand ask for a copy asked if the care plants hospital staff, ASM On 4/19/18 at 11:50 letter faxed by the edirector on 4/19/18 "To Whom it May Consideration of the ER. All of these the patient's recorded electronic charting some on 1/19/18 at appropriate the patient's recorded a fax repoincluded the document of the second of of	a.m., ASM #2 was asked to orm. ASM #2 stated the ood relationship with the local stated she asked the hospital ted facility staff to provide ent is transferred) and the ent is transferred) and the ent is transferred) and the ent is transferred by the last stated the facility staff also give a report and even the hospital to be with the can arrive. When asked to fithe information that was a staff when Resident #110 the hospital, ASM #2 stated ead of the emergency room of the information sent. When an goals are provided to the #2 stated they are not.  In a.m., ASM #2 provided a emergency department clinical that documented, oncern for the information gradient is sent to be documents are scanned into a didition, they also call a int before the patient is sent to be documents are scanned into a in the ER through our EPIC	F	622			











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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>)MB NC</u>	<u>), 0938-0391</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		TE SURVEY MPLETED
		495261	B. WING	·		04	/19/2018
NAME OF F	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
HEDITAC	E HALL NRSG AND	REHAR		1	122 MORVEN PARK ROAD NW		
HERMAG	IL HALL MIGO AND			l	LEESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	Continued From pa	age 7	F	622	) 		
1 022		nented, "4. Should it become					
		an emergency transfer or					
	discharge to a hosp	oital or other related institution,					
	our facility will imple	ement the following					
		tify the receiving facility that the					
	form to send with the	aded. Prepare a transfer					
	TOTAL TO SCHO WILL I	io residenti					
	No further informat	ion was provided prior to exit.					
		failed to provide documented sfer requirements for Resident and 02/05/18.					
	01/05/17 with recer and 02/09/18, with were not limited to: blood sugar) (1), de	admitted to the facility on nt readmissions on 02/02/18 diagnoses that included but dementia, hypoglycemia (low epression, chronic kidney igh blood pressure, and heart					
	assessment, a 30 c with an assessment coded the resident BIMS (brief intervier indicating she has a of daily decision may as requiring extens	DS (minimum data set) day Medicare assessment, it reference date of 03/07/18, as scoring an "11" on the it was for mental status) score, moderate cognitive impairment aking. The resident was coded ive assistance of one staff er activities of daily living.	: 				
	01/30/18, documer ER (emergency roo	elephone Orders Form" dated atted in part, "Send Resident to om) for evaluation. TO name of doctor/name of nurse	1				

The nurse's note dated 01/30/18 at 12:57 p.m.

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UENIER	(S FUR MEDICARE	& MEDICAID SERVICES				IND INO	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY MPLETED
		495261	B. WING	;		04/	/19/2018
NAME OF P	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HEDITAC	STUALL NOCC AND	DELIAD		1	122 MORVEN PARK ROAD NW		
HERITAG	SE HALL NRSG AND I	KENAD		L	LEESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	Continued From pa	ane 8	F	622	; }		
	family by opening e sugar 63 at 12:45 [	t, "Resident responding to eyes and moaning. Blood p.m.]. MD (medical doctor)					
	treat severe low blo like Resident to go	or glucagon (medicine used to bood sugar) (2). Family would to hospital for CT (computed					
	topography) Scan (a picture of the inside of a part of your body that is made by a computerized machine) (3). Famillly [sic] had said last evening that they wanted Resident to stay here and be						
		out have since changed their with order to send to ER for					
	02/05/18, documen Send Resident to E	elephone Orders Form" dated atted in part, "T.O. from M.D. ER for evaluation and treatment rpoglycemia (name of se taking order)".					
	part, "5:23 PM: At 5 observed Resider normally, BS (blood informed with new of	dated 02/05/18 documented in 5pm called to room by staff in unresponsive, breathing d sugar) checked 22, MD order to give glucagon. RP informed5:51 PM: Blood					·
	responsive now, tal also of blood sugar checked again 80.5 Resident to go to El	r. Resident became kingson into visit. Informed result8:05 PM: Blood sugar Son at bedside wanted R. MD informed and spoke to to ER nurse (ER nurse's					
	that a care plan with	al record failed to evidence h goals was included in the sfer documentation.					

An interview was conducted with administrative

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		495261	B. WING			04	/19/2018
NAME OF I	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE HALL NRSG AND	REHAB			MORVEN PARK ROAD NW		
·				LEC	ESBURG, VA 20176	**************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	Continued From pa	age 9	F€	522			
, 322	staff member (ASM on 04/19/18 at 08:4 facility's "checklist" work that is to be s Resident is transfectecklist failed to do be sent as well. We sends the comprehen a resident is	M) #2, the director of nursing, 45 a.m. ASM #2 provided the that documents the paper ent in an envelope when a rred to another facility. The locument that a care plan is to hen asked if the facility staff tensive care plan with goals transferred to the hospital, or. ASM #2 was made aware		<i>(</i>			
	practical nurse) #2 regarding the pape Resident when tran #2 stated, "once we doctor) to send a R face sheet w/ insur- recent x-rays, code nurses notes pertin pertinent MD notes paperwork in envel giving envelope to technician)". LPN a plans or any docum goals. LPN #2 state	onducted with LPN (licensed on 04/19/18 at 10:06 a.m., rwork that is sent with a asferred to the hospital. LPN e get order from MD (medical desident to the hospital, we get ance info, any recent labs; any e status, medical directive, sent to situation and any ." LPN #2 stated then we put ope and send it with patient by EMT (emergency medicine #2 was asked if they send care nentation regarding resident sed they do not send care plansing goals when transferring ospital.					
	the above findings	istrator, was made aware of on 4/19/18 at 10:45 a.m.					
	No further informat	ion was provided prior to exit.	:				
	following website:	was obtained from the					
	THURS THE POHIDANING						

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(2) This information was obtained from the

Event ID: 91RI11

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CENTE	45 FOR MEDICARE	& MEDICAID SERVICES			Ol,	VID INO. 0938-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION DING	and the	(X3) DATE SURVEY COMPLETED
		495261	B. WING		ALAAAMAM	04/19/2018
	PROVIDER OR SUPPLIER SE HALL NRSG AND	REНАВ		STREET ADDRESS, CITY, ST 122 MORVEN PARK ROAL LEESBURG, VA 20176	D NW	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PL IX (EACH CORRECTI CROSS-REFERENCI	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPE FICIENCY)	BE COMPLÉTION
F 622	San (3) This information following website:	ge 10 m-webster.com/dictionary/CT was obtained from the inic.org/drugs-supplements/gl	F	622		
	all required information care plan goals) was	failed to provide evidence that tion (including comprehensive is provided to the hospital staff was transferred to the				
	12/29/17 and disch diagnoses of but no with hypoxia, pneur effusion, hypoxemia high blood pressure aneurysm, cardiac failure, pacemaker, lung cancer. The n Data Set) was an a ARD (Assessment	admitted to the facility on arged on 1/18/18 with the of limited to respiratory failure monitis, malignant pleural a, dysphagia, falls, diabetes, e, osteoarthritis, cerebral arrhythmias, acute kidney acidosis, heart failure, and nost recent MDS (Minimum dmission assessment with an Reference Date) of 1/5/18. Doded as impaired in ability to sions.				
	note dated 1/18/18 resident presented (respirations) 28, ut with breaths, breath saturation) on 4L (for (blood pressure) 13 98.5, skin warm, dread of bed) eleva	cal record revealed a nurse's that documented, "This a.m. with respiratory distress, respilizing essesory [sic] muscles as shallow, 80% (oxygen our liters) of O2 (oxygen), BP 0/74, temp (temperature) and ashy, lips cyanotic, HOB ted the whole time. Resident name being called. MD				





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If continuation sheet Page 11 of 53



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X1   PROVIDER CAR SUPPLER   X2   PROVIDER SUPPLER   X2   PROVIDER CAR SUPPLER   X495261   X   X   X   X   X   X   X   X   X		C EOD MEDICARE				0		. 0938-0391
NAME OF PROVIDER OR SUPPLIER  495261  STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LESBURG, W. 20176  SUMMANY STREED ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LESBURG, W. 20176  SUMMANY STREED OF DEPOCRACIES PROVIDER SHALL OF CORRECTION RECULATORY OR LSC IDENTIFYING INFORMATION)  F 622 Continued From page 11 (medical doctor) made aware, 911 (emergency services number) activated, Duoneb [1] provided with 10L on 02 [sic]. Chest tube drained 250 MLs (millilaters) [sic] of red colored fluid. o2 [sic] sat (saturation) went to 97%, resident continued to utilize assessory [sic] muscless with resp. (respirations) Resp at 24. EMT's (Emergency Medical Technicians) arrived assessed resident, transported to hospital. Report called to hospital making them aware of resident being in hospital. POA stated resient [sic] was being transferred to (another hospital). (Second hospital) phoned, resident admitted with respiratory failure.  Further review of the clinical record failed to reveal any evidence of what documentation was sent with the resident self end with respiratory failure.  Further review of the clinical record failed to reveal any evidence of what documentation that was provided to the hospital emergency department at the time the resident's care plan goals were provided, as required.  On 4/19/18 at 11:30 a.m., the facility provided a fax they received on 4/19/18 at 16:50 a.m., from the hospital, of copies of the documentation that was provided to the hospital emergency department at the time the resident's care plan goals were provided, as required.  On 4/19/18 at approximately 8:44 a.m., in an interview with ASM #2 (Administrative Staff Member) the DON (Director of Nursing) she stated that the facility was not sending the care				(Y2) MI II	TIPLEC		T	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL NRSG AND REHAB  SUMMARY STATIMENT OF DEPICIPACIES  [MAI ID   SUMMARY STATIMENT OF DEPICIPACIES   ID   PROVIDERS TRAIN OF CORRECTION   IELESBURG, VA 20176    FOR ID   PROVIDER STATIMENT OF DEPICIPACIES   ID   PROVIDERS TRAIN OF CORRECTION   COMPLETION   IELESBURG, VA 20176   FOR IT   IELESBURG, VA 20176   IE				1 ' '				
Text			495261	B. WING			04/	/19/2018
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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495261	B. WING			04/19/2018
	ROVIDER OR SUPPLIER	REHAB		STREET ADDRESS, CIT 122 MORVEN PARK I LEESBURG, VA 20	ROAD NW	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD RENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 622	Continued From pa	ige 12	F 6	22		
	administrator was r No further informat [1] Duoneb - A com albuterol and ipratry wheezing, difficulty and coughing in per pulmonary disease that affect the lungs bronchitis (swellings to the lungs) and eta sacs in the lungs). Information obtained https://medlineplusty. Notice Requiremer CFR(s): 483.15(c)(3) Notice Before a facility transident, the facility (i) Notify the reside representative(s) of the reasons for the language and man facility must send a	abination medication of opium used to prevent breathing, chest tightness, ople with chronic obstructive (COPD; a group of diseases and airways) such as chronic of the air passages that lead mphysema (damage to the air ed fromgov/druginfo/meds/a601063.h ats Before Transfer/Discharge 3)-(6)(8)	F 6	Resident been noti provide a resident's 12/17/17.  Identific: Practices All other transferre been affe	ation of Deficient s/Corrective Action(s) residents discharged ar ed from the facility may ected. The Social Service	led to ce for the l on  : nd/or / have
	Long-Term Care O (ii) Record the reas discharge in the reaccordance with pa and	mbudsman. sons for the transfer or sident's medical record in aragraph (c)(2) of this section; otice the items described in this section.		conduct a have been in the past risk will and the residents A facility	and/or Admissions Dire a 100% audit of all resion n discharged and/or transt 30 days. Residents id be corrected at time of equired notifications to responsible party will y Incident & Accident F letted for each negative	dents who nsferred entified at discovery the be made. Form will

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
	495261	B. WING		04	/19/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP COI 122 MORVEN PARK ROAD NW LEESBURG, VA 20176			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE	
(c)(8) of this section discharge required made by the facility resident is transferr (ii) Notice must be before transfer or d (A) The safety of in be endangered und this section; (B) The health of in be endangered, unthis section; (C) The resident's hallow a more imme under paragraph (c) (D) An immediate the required by the resident paragraph (c) (E) A resident has redays.  §483.15(c)(5) Continotice specified in provided the foil (ii) The effective days.  §183.15(c)(5) Continotice specified in provided the foil (iii) The location to transferred or dischedition in the statement of the including the name and telephone number receives such required obtain an appeal completing the form hearing request; (v) The name, addressed in the section of the same and the such that the section is the section of the secti	ied in paragraphs (c)(4)(ii) and now, the notice of transfer or under this section must be at least 30 days before the red or discharged. made as soon as practicable ischarge whendividuals in the facility would der paragraph (c)(1)(i)(C) of dividuals in the facility would der paragraph (c)(1)(i)(D) of dividuals in the facility would der paragraph (c)(1)(i)(D) of mealth improves sufficiently to diate transfer or discharge, ()(1)(i)(B) of this section; ransfer or discharge is dent's urgent medical needs, ()(1)(i)(A) of this section; or not resided in the facility for 30 dents of the notice. The written paragraph (c)(3) of this section llowing: ransfer or discharge; te of transfer or discharge; which the resident is		Systemic Change(s): Facility policy and procedure reviewed. No revisions are withis time. The Administrator Regional Nurse Consultant withe facility's social worker(s) administration on the require resident's responsible party a ombudsman be notified of redischarges/transfers.  Monitoring: The Social Services Director responsible for maintaining of The Social worker, and/or A Director will conduct chart a of all residents who have been and/or transferred from the fany/all negative findings an will be corrected at time of disciplinary action will be ta needed. Aggregate findings audits will be reported to the Assurance Committee quarter review, analysis, and recomfor change in facility policy, and/or practice.  Completion Date: May 30,	varranted at and/or vill inservice and nursing ment that a und the state sident will be compliance, dmissions undits weekly en discharged facility, dor errors discovery and aken as of these e Quality erly for mendations, procedure,		

If continuation sheet Page 14 of 53



CLIVIL	10 TOR WEDIONIL	. G WILDIOAID OLIVIOLO				<u> </u>	VID NO.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	TIPLE CONSTRUCTI	ION			E SURVEY PLETED
		495261	B. WING				04/	19/2018
	PROVIDER OR SUPPLIER  BE HALL NRSG AND	REHAB		STREET ADDRES 122 MORVEN PA LEESBURG, V		ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH (	VIDER'S PLAN OF COR CORRECTIVE ACTION S REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 623	and developmental disabilities, the mai telephone number the protection and a developmental disa C of the Developmental Bill of Rights A codified at 42 U.S.C (vii) For nursing factorial address and agency responsible advocacy of individuestablished under the for Mentally III Individual Section 11 of Mentally III Individual Section 12 of Mentally III Individual Section 13 of Mentally III Individual Section 14 of Mentally III Individual Section 15 of Mentally III Individual Section 16 of Mentally III Individual Section 17 of Mentally III Individual Section 18 of	mbudsman; ility residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with abilities established under Part ental Disabilities Assistance of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the for the protection and uals with a mental disorder the Protection and Advocacy iduals Act.  ages to the notice. the notice changes prior to er or discharge, the facility cipients of the notice as soon the updated information	F	523				

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CENTERS	OR MEDICARE	& MEDICAID SERVICES				<u>OMB NO</u>	0. 0938-0391
STATEMENT OF I AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			STRUCTION		TE SURVEY MPLETED
		495261	B. WING	W-44	TO THE SECOND CONTRACT OF THE SECOND CONTRACT	04	1/19/2018
	ALL NRSG AND	REHAB		122 MC	FADDRESS, CITY, STATE, ZIP CODE DRVEN PARK ROAD NW BURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFID TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 623 Co	ntinued From pa	ge 15	F 6	23			
res tra	ident representa	red written notification to the tive for a facility-initiated ital for one of 33 residents in Resident #134.					
rep no	resentative with	ed to provide Resident #134's the required written he resident was sent to the					
Th	e findings include	e:					
12. dia wit eff hig and fail lun Da AR Th	'29/17 and disch gnoses of but no h hypoxia, pneur usion, hypoxemia h blood pressure eurysm, cardiac ure, pacemaker, g cancer. The nota Set) was an au.D (Assessment	admitted to the facility on arged on 1/18/18 with the ot limited to respiratory failure monitis, malignant pleural a, dysphagia, falls, diabetes, e, osteoarthritis, cerebral arrhythmias, acute kidney acidosis, heart failure, and most recent MDS (Minimum dmission assessment with an Reference Date) of 1/5/18.					
not res (re wit sat (blo 98. (he abl	te dated 1/18/18 ident presented spirations) 28, ut he breaths, breath uration) on 4L (food pressure) 13 5, skin warm, dread of bed) elevale to respond to	cal record revealed a nurse's that documented, "This a.m. with respiratory distress, respilizing essesory [sic] muscles as shallow, 80% (oxygen our liters) of O2 (oxygen), BP 0/74, temp (temperature) and ashy, lips cyanotic, HOB ted the whole time. Resident name being called. MD ade aware, 911 (emergency					



services number) activated, Duoneb [1] provided



Facility ID: VA0115

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CENTERS FOR MEDICARE	: & MEDICAID SERVICES			(	<u> </u>	<u>. 0938-0391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495261	B. WING	·		04	/19/2018
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE HALL NRSG AND	REHAB		1	22 MORVEN PARK ROAD NW		
			L	_EESBURG, VA 20176		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 623 Continued From partial with 10L on 02 [sic] (milliliters) [sic] of re (saturation) went to utilize assessory [sic 24. EMT's (Emerging arrived assessed resident by the same of resident by resient [sic] was be the same of resident by the same of the reveal any evidence was provided writted resident was transfer 1/18/18.  On 4/19/18 at approximately the DON stated that the facilian notification at the tire because they did not start sending the February, 2018. (N	age 16  J. Chest tube drained 250 MLs ed colored fluid. o2 [sic] sat o 97%, resident continued to ic] muscles with resp. Resp at ency Medical Technicians) esident, transported to alled to hospital making them being transferred. POA (Power Id., left message to return call to placed again, left message to ter returned call and was eing in hospital. POA stated ing transferred to (another hospital) phoned, resident		623	ŧ		
	a.m., the Administrator was findings. No further					



[1] Duoneb - A combination medication of



Facility ID: VA0115

If continuation sheet Page 17 of 53



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING	***************************************	04/19/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	
HERITA	GE HALL NRSG AND	REHAB		122 MORVEN PARK ROAD NW LEESBURG, VA 20176	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 625	wheezing, difficulty and coughing in pupulmonary disease that affect the lung bronchitis (swelling to the lungs) and esacs in the lungs). Information obtain https://medlineplustml Notice of Bed Hold CFR(s): 483.15(d) §483.15(d) Notice §483.15(d)(1) Notion ursing facility trarthe resident goes nursing facility muthe resident or resspecifies— (i) The duration of any, during which return and resume facility; (ii) The reserve be plan, under § 447. (iii) The nursing fabed-hold periods, paragraph (e)(1) oresident to return; (iv) The informatio of this section.	ropium used to prevent y breathing, chest tightness, exple with chronic obstructive expoperation (COPD; a group of diseases is and airways) such as chronic gof the air passages that lead emphysema (damage to the air ed from s.gov/druginfo/meds/a601063.h d Policy Before/Upon Trnsfr (1)(2)  of bed-hold policy and returnate before transfer. Before a resident to a hospital or on therapeutic leave, the st provide written information to ident representative that the state bed-hold policy, if the resident is permitted to residence in the nursing d payment policy in the state 40 of this chapter, if any; cility's policies regarding which must be consistent with f this section, permitting a and in specified in paragraph (e)(1)		F625 Corrective Action(s): Residents #110, #64, #134 a been notified of the facilitie and procedure and the requireviewed and issued in writt and the RP when discharge when going out on therapeu Incident and Accident report completed for each resident review.  Identification of Deficient Corrective Action(s): All other residents could poor The Bed-Hold policy and for the nursing station for after the hospital to be completed nurse. The Social Services of director will be responsible hour transfer notification of residents and/or Responsible hour transfer notification of residents and/or Responsible hour transfer notification of residents and no changes are time. The Social Services Director and licensed staff I by the administrator on the requirement and the proper of Bed-Hold policy.	and their RP's have s bed-hold policy frement that it ing to the resident to the hospital or ttic leave. An t has been identified in the  Practice(s) and tentially be affected. forms are now kept at hour's transfers to l by the charge director/Admissions for normal business fall bed-holds to e parties.  tedure has been the warranted at this forector, Admissions have been inserviced bed-hold

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CENTER	KS FUR MEDICARE	& MEDICAID SERVICES			(	<u> MB NO.</u>	<u>0938-03</u> 91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		E CONSTRUCTION		E SURVEY PLETED
		495261	B. WING	;	*	04/	19/2018
NAME OF F	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIEDITAC	E HALL NRSG AND I	DELLAD		1	22 MORVEN PARK ROAD NW		
HERHAG	E HALL NKSG AND I	COAD		L	EESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
	resident representa specifies the duratic described in paragr This REQUIREMEN by: Based on staff inte and clinical record representative the facility staff faile hold policy was proved facility initiated transithe survey sample, #134.  1. The facility staff faile hold policy when the hospital on 3/2. The facility staff faile hold information to Figure 19 and 19 an	to the resident and the tive written notice which on of the bed-hold policy aph (d)(1) of this section.  IT is not met as evidenced rview, facility document review eview, it was determined that d to evidence a written bed vided within 24 hours of a sfer for three of 33 residents in Residents #110, #64 and ailed to provide Resident ve written notification of the n the resident was discharged 11/18.  Failed to provide written bed Resident #64's responsible dent was discharged to the sand 02/05/18.  Failed to provide Resident esentative the required bed on the resident was sent to the ailed to provide Resident ewitten notification of the n the resident was discharged 11/18.		625	Monitoring: The Admissions Director and Social Sc Director are responsible for compliance transfers/discharges from the facility waudited the by the Social service direct Admissions Director to ensure proper to notification was completed at the time or therapeutic leave. Any/all negative fix will be corrected at time of discovery, results of these audits will be forwarde Quality Assurance Committee quarter review, analysis, and recommendations change in facility policy, procedure, an practice.  Completion Date: May 30, 2018	e. All ill be or and/or oed-hold of transfer indings The d to the y for	
		ted on 3/16/18. Resident					

#110's diagnoses included but were not limited to

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<del></del>		OMB NO. 09	38-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SU COMPLE	
		495261	B. WING			04/19/	2018
NAME OF F	PROVIDER OR SUPPLIER	1		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
		251145		122	MORVEN PARK ROAD NW		
HERITAG	SE HALL NRSG AND I	KEHAB		LE	ESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE C	(X5) OMPLETION DATE
	Continued From paragior depressive decommunication defi #110's most recent 30 day Medicare as (assessment referenthe resident's cognidecision-making as Review of Resident revealed a nurse's in 2000H (8:00 p.m.) of from his (sic), this mand him (sic) starte and tried to hit to (sobserved combative This nurse informed nursing) and MD (mand left message to Further review of Refailed to reveal the finformation regarding Resident #110"s regree On 4/18/18 at 1:43	ge 19 isorder, cognitive icit and pneumonia. Resident MDS (minimum data set), a sessment with an ARD ence date) of 4/11/18, coded tive skills for daily moderately impaired.  #110's clinical record note that documented, "At resident observed walking out surse redirected the resident d to be agitated with this nurse ic) this nurse. Resident e with staff when redirected. d to (sic) DON (director of nedical doctor) and received a ler). Sent resident to ER for Eval (evaluation) and tx Power of attorney) was called o call back."  resident #110's clinical record facility staff provided written ng the bed hold policy to presentative.  p.m., an interview was	·	625			
	admissions director for providing the bed asked to explain the hold policy to a resident is discharge stated she calls the leaves a message it family member. OS	M (other staff member) #8 (the and the person responsible d hold policy). OSM #8 was exprocess for providing the bed dent's representative when a sed to the hospital. OSM #8 resident's family member and f she is not able to reach the EM #8 stated when she					

notation whether the family member elects or

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
	495261	B. WING		04/40/2049	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND I			STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	04/19/2018	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION	
written information OSM #8 stated, "No I'm not seeing them more verbal but it's On 4/18/18 at 1:51 bed hold agreemen discharge on 3/11/1 hold information wa The form was dated "Bed Hold Agreeme The undersigned w of Resident #110), whe facility for a host leave. The resident \$305.00 per day to three days is due in reservation will be a This bed hold may I written request static undersigned wishes payment in advance referenced above. acknowledges that understands the process of the Agreement. I'We a transfer funds from account to pay the count to pay the count to pay the count to pay the count to days. Yes that the Admission Adocuments dated effect throughout the Resident returns agreement is binding.	When asked if she provides regarding the bed hold policy, of typically at the time because in person at the time so it's done on admission."  p.m., OSM #8 provided the trelated to Resident #110's 8. OSM #8 confirmed the bed s provided over the phone. d 3/12/18 and documented, ent ish to reserve a bed for (name while he or she is away from pitalization or therapeutic the shall be obligated to pay shold a bed. A deposit for advance. The bed effective beginning 3/11/18. The extended, by making a night he number of days the state of the bed hold charges as the undersigned the/she has read and fully evisions of the Bed Hold uthorize (name of facility) to the Resident's personal cost for the requested bed No X. I/We understand agreement and all associated remain in full force and the bed hold period and when	F 62	1		
The following handw documented on the	vritten notes were				

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

Event ID: 91RI11

Facility ID: VA0115

If continuation sheet Page 21 of 53



CENTER	KS FUR MEDICARE	& MEDICAID SERVICES			OIVIE	NO. 0938-0391		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	. (X	(X3) DATE SURVEY COMPLETED		
		495261	B. WING		_	04/19/2018		
	PROVIDER OR SUPPLIER  BE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STA 122 MORVEN PARK ROAD LEESBURG, VA 20176				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	(EACH CORRECTIVE CROSS-REFERENCE)	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)			
F 625	hold @ (at) 305.00 husband. Will Call DTR (Daughter) ca Passing on Bed ho need (sic) Memory available at time of On 4/18/18 at 5:10 staff member) #1 (the director of nursabove findings.  No further informat 2. The facility staff hold information to party when the resi hospital on 01/30/1 Resident #64 was a 01/05/17 with recer and 02/09/18, with were not limited to: blood sugar) (1), dedisease, arthritis, he failure.  The most recent Massessment, a 30 cwith an assessment a 30 cwith an assessment of daily decision mass requiring extens member for all of hemost for a	anday) 1:50p. Offered Bed a day. Wants to speak w/ her me back with answer today. Illed back 3:40 (p.m.) 3/13. Id on North unit. She thinks he Care for his Dementia, if Bed D/C (discharge)."  p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the ion was provided prior to exit. failed to provide written bed Resident #64's responsible dent was discharged to the 8 and 02/05/18.  admitted to the facility on an treadmissions on 02/02/18 diagnoses that included but dementia, hypoglycemia (low expression, chronic kidney igh blood pressure and heart DS (minimum data set) day Medicare assessment, at reference date of 03/07/18, as scoring an "11" on the w for mental status) score, moderate cognitive impairmentaking. The resident was coded ive assistance of one staffer activities of daily living.		625				
		elephone Orders Form" dated ted in part, "Send Resident to						

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>O</u>	<u>MB NO. (</u>	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495261	B. WING	Mantiniani		04/1	9/2018
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	PROVIDER OR SUPPLIER SE HALL NRSG AND I	REHAB		122	EET ADDRESS, CITY, STATE, ZIP CODE  MORVEN PARK ROAD NW  ESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	<del></del>	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	(telephone order) (taking order)".  The nurse's note day documented in partiamily by opening esugar 63 at 12:45 [aware with order for treat severe low blooking Resident to go topography) Scan (of your body that is machine) (3L). Far evening that they wand be kept comfort	om) for evaluation. TO name of doctor/name of nurse ated 01/30/18 at 12:57 p.m. t, "Resident responding to eyes and moaning. Blood p.m.]. MD (medical doctor) or glucagon (medicine used to lood sugar) (2). Family would to hospital for CT (computed a picture of the inside of a part made by a computerized millly [sic] had said last wanted Resident to stay here rtable, but have since changed are with order to send to ER	F	525			
	part, "5:23 PM: At 8observed Reside normally, BS (blood informed with new (responsible party) sugar rechecked 7 responsive now, ta also of blood sugar checked again 80. Resident to go to E sonReport given name)."  On 4/19/18 at 07:36	dated 02/05/18 documented in 5pm called to room by staff int unresponsive, breathing disugar) checked 22, MD order to give glucagon. RP informed5:51 PM: Blood 1. Resident became likingson into visit. Informed result8:05 PM: Blood sugar Son at bedside wanted ER. MD informed and spoke to to ER nurse (ER nurse's					
	copies of the "Bed #64's hospital adm 02/05/18 to this sur	Hold Agreement" for Resident issions on 01/30/18 and veyor for review. On the document, in the area provided					



for the Responsible Party's (RP) Signature



Facility ID: VA0115

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CENTER	13 LOW MEDICANE	A MEDICAID SERVICES			OND NO. 0330-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495261	B. WING		04/19/2018
	PROVIDER OR SUPPLIER	DEUAD		STREET ADDRESS, CITY, STATE, ZIP CC 122 MORVEN PARK ROAD NW	DE
HERITAG	E HALL NRSG AND	KENAB		LEESBURG, VA 20176	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLÉTION
F 625	Continued From pa	age 23	F	625 ·	
F 023	documented, "Agree 02/05/18 bed hold of for the Responsible documented, "verb representative who document was OSI admissions director During an interview member (ASM) #2, on 04/19/18 at 08:5 the RP's were provided hold. ASM #2 and she would cheer An interview was admissions director OSM #8 was asked were provided to the ASM #2 was made ASM #1, the administration of ollowing website: https://medlineplus.	eed via phone call". On the document, in the area provided a Party's Signature al agreement". The facility signed each bed hold M (other staff member) #8, the	11 manuary 11/1000 - 11/1000 - 11/1000 - 1	525	
	following website: https://www.merriar San	m-webster.com/dictionary/CT			
	(3) This information following website:	was obtained from the inic.org/drugs-supplements/gl			

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	TO TOTTIMEDIOTE				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495261	B. WING		04/19/2018
	PROVIDER OR SUPPLIER  GE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	ODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLÉTION
F 625	#134's resident rep	failed to provide Resident resentative the required bed en the resident was sent to the		625	
	12/29/17 and disch diagnoses of but no with hypoxia, pneur effusion, hypoxemi high blood pressure aneurysm, cardiac failure, pacemaker lung cancer. The r Data Set) was an a ARD (Assessment	admitted to the facility on arged on 1/18/18 with the of limited to respiratory failure monitis, malignant pleural a, dysphagia, falls, diabetes, e, osteoarthritis, cerebral arrhythmias, acute kidney, acidosis, heart failure, and nost recent MDS (Minimum dmission assessment with an Reference Date) of 1/5/18. oded as impaired in ability to sions.			
	note dated 1/18/18 resident presented (respirations) 28, u with breaths, breath saturation) on 4L (f (blood pressure) 13 98.5, skin warm, dr (head of bed) eleval able to respond to (medical doctor) may be services number) a with 10L on 02 [sic] (milliliters) [sic] of residuation) went to utilize assessory [siz] 4. EMT's (Emergarrived assessed residuations)	ical record revealed a nurse's that documented, "This a.m. with respiratory distress, resp tilizing essesory [sic] muscles as shallow, 80% (oxygen our liters) of O2 (oxygen), BP 80/74, temp (temperature) y and ashy, lips cyanotic, HOB atted the whole time. Resident name being called. MD ade aware, 911 (emergency activated, Duoneb [1] provided. Chest tube drained 250 MLs and colored fluid. o2 [sic] sat 97%, resident continued to ic] muscles with resp. Resp at ency Medical Technicians) asident, transported to alled to hospital making them			

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aware of resident being transferred. POA (Power

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Facility ID: VA0115

If continuation sheet Page 25 of 53



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495261	B. WING		0,	4/19/2018	
	PROVIDER OR SUPPLIER  SE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 122 MORVEN PARK ROAD NW LEESBURG, VA 20176			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE	
F 625	facility, Call to POA return call. POA lat aware of resident bresient [sic] was be hospital). (Second admitted with respitation of the reveal any evidence (RP) was provided hold notification whospital on 1/18/18  On 4/19/18 at 9:00 #8 (Other Staff Mershe stated that a behim (the resident restated, "He made it (time of admission) one dollar outside coos M#8 stated, "He several times." She the resident representation one dollar outside that he refused to transition.  On 4/19/18 at 10:5° made aware of the information was provided and ipratro wheezing, difficulty and coughing in per	In, left message to return call to placed again, left message to the returned call and was eing in hospital. POA stated ing transferred to (another hospital) phoned, resident ratory failure."  The clinical record failed to eithe resident representative with a written (or verbal) bed en the resident was sent to the enthe resident was sent to the maintenance.  The Admissions Director, and hold "was not provided for expresentative)." OSM #8 very clear from the get-go that he did not want to spend of what Medicare provided." In made it extremely clear estated that because of such, entative was not provided a riting or verbally, other than in the admission paperwork at the control of the cont		625			

PRINTED: 04/26/2018 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '			TE SURVEY MPLETED
	495261	B. WING		04	/19/2018
	REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LEESBURG, VA 20176		
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
that affect the lungs bronchitis (swelling to the lungs) and er sacs in the lungs). Information obtaine https://medlineplus.tml Qrtly Assessment at CFR(s): 483.20(c) §483.20(c) Quarter A facility must asse quarterly review ins and approved by Conce every 3 month This REQUIREMEN by: Based on staff intereview, it was deterfailed to complete a assessment within two of 33 residents Residents #1 and #  1. The facility staff f #1's quarterly MDS resident's most reconnual assessment reference date) of 1  2. The facility staff f #2's quarterly MDS resident's most reconnual assessment reference date) assessment refer	s and airways) such as chronic of the air passages that lead mphysema (damage to the air d from gov/druginfo/meds/a601063.h at Least Every 3 Months  By Review Assessment ss a resident using the trument specified by the State MS not less frequently than as.  NT is not met as evidenced rview and clinical record mined that the facility staff a MDS (minimum data set) the required time frame for in the survey sample, 2.  Failed to complete Resident every three months. The ent completed MDS was an with an ARD (assessment 1/15/17.  Failed to complete Resident every three months. The ent completed MDS was a ent with an ARD of 11/28/17.		F638 Corrective Action(s): Resident #1 & #2 have had a Comprehensive Significant Char Assessment completed to accura assess each resident. Resident #1 have had their comprehensive car revised to reflect resident specific approaches and interventions to their specific needs.  Identification of Deficient Prace Corrective Action(s): All other residents may have pot been affected. A 100% review of assessments will be done by the and/or designee to ensure that all requiring a quarterly MDS have completed in the last 92 days. An negative findings will be reporte resident care coordinator at time discovery for immediate correcti Comprehensive care plans will be as needed to reflect resident spec measurable objectives and interv  Systemic Change(s): The facility Policy and Procedur been reviewed and no changes an warranted at this time. The RCC inserviced by the Regional Nurse Consultant on scheduling and co	tely tely & #2 tre plan c address  etice and entially fresident RCC residents had one ny/all d to the of on. e revised diffic entions.  e has e has been e mpleting	
1. The facility staff f	ailed to complete Resident				
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LETTER CONTINUED FROM PARTY OF LETTER CONTINUED TO THE LETT	A95261  PROVIDER OR SUPPLIER  SE HALL NRSG AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26 that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Information obtained from https://medlineplus.gov/druginfo/meds/a601063.h tml  Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c)  §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced	A BUILDING  495261  A BUILDING  A BUILDING  A BUILDING  A BUILDING  BE HALL NRSG AND REHAB  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Information obtained from https://medlineplus.gov/druginfo/meds/a601063.html  Qrtly Assessment at Least Every 3 Months  CFR(s): 483.20(c)  §483.20(c) Quarterly Review Assessment  A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and clinical record review, it was determined that the facility staff failed to complete a MDS (minimum data set) assessment within the required time frame for two of 33 residents in the survey sample,  Residents #1 and #2.  1. The facility staff failed to complete Resident #1's quarterly MDS every three months. The resident's most recent completed MDS was an annual assessment with an ARD (assessment reference date) of 11/15/17.  2. The facility staff failed to complete Resident #2's quarterly MDS every three months. The resident's most recent completed MDS was a quarterly assessment with an ARD of 11/28/17.  The findings include:	STREET ADDRESS, CITY, STATE, ZIP CODE  122 MORVEN PARK ROAD NW LEESBURG, VA 20176  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 26  That affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs).  Information obtained from https://medlineplus.gov/druginfo/meds/a601063.h itnl  Ortly Assessment at Least Every 3 Months  CFR(s): 483.20(c)  Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.  This REQUIREMENT is not met as evidenced by:  Based on staff interview and clinical record review, it was determined that the facility staff failed to complete a MDS (minimum data set) assessment within the required time frame for two of 33 residents in the survey sample, Residents #1 and #2.  1. The facility staff failed to complete Resident #1's quarterly MDS every three months. The resident's most recent completed MDS was an annual assessment with an ARD (assessment reference date) of 11/15/17.  2. The facility staff failed to complete Resident #2's quarterly MDS severy three months. The resident's most recent completed MDS was a quarterly assessment with an ARD of 11/28/17.  The findings include:  1. The facility staff failed to complete Resident #2's quarterly MDS severy three months. The resident's most recent completed MDS was a quarterly assessment with an ARD of 11/28/17.  The facility staff failed to complete Resident #2's quarterly MDS severy three months. The resident's most recent completed MDS was a quarterly assessment with an ARD of 11/28/17.  The facility staff failed to complete Resident #2's quarterly MDS severy three months. The resident's most recent completed MDS was a quarterly assessment with an ARD of 11/28/17.  The facility staff failed to complete Resident #2's quarterl	### A SUND PLIES   SUND PLIES   ### ALL NRSG AND REHAB   SUND PLIES   ### SUND PLIES   SUND PLIES   ### SUND PLIES   ### SUND PLIES   SUND PLIES   ### SUND PROVIDERS PLAN OF CORRECTION   ### COORDINATION OF LESS IDENTIFYING INFORMATION)   ### PREFIX   ### COORDINATION OF CORRECTION   ### COORDINATION OF CORRECTION OF CORRECTION OF CORRECTION   ### COORDINATION OF CORRECTION OF

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

Event ID:91RI11

Facility ID: VA0115

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495261	B. WING	New York Construction Construct		04/	19/2018
	PROVIDER OR SUPPLIER GE HALL NRSG AND			122	REET ADDRESS, CITY, STATE, ZIP CODE  MORVEN PARK ROAD NW ESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	Κ	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 638	resident's most re annual assessme reference date) of Resident #1 was a 12/23/16. Reside were not limited to swallowing and at Review of Reside the most recently MDS with an ARD On 4/19/18 at 9:1 conducted with RI MDS coordinator) assessments sho the assessments quarter. When as quarter meant, RN RN #1 was made RN #1 reviewed the assessment should refer the same reference of the same results and reviewed the same reference of the same r	S every three months. The cent completed MDS was an an every three months. The cent completed MDS was an every month and ARD (assessment 1/1/15/17.  Admitted to the facility on every month and months of muscle weakness, difficulty proormal posture.  Int #1's clinical record revealed completed MDS was an annual every months.	F 6	338	Monitoring: The RCC is responsible for compliance The RCC and/or designee weekly ME audits coinciding with the MDS calen to monitor for timely completion of M assessments per the RAI guidelines. Any/all negative findings will be report to the DON and the RCC will make corrections at the time of discovery. Aggregate findings of the audits will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facilit policy, procedure, and/or practice. Completion Date: May 30, 2018	OS dar MDS orted be	
	On 4/19/18 at 9:2- staff member) #1 aware of the abov	4 a.m., ASM (administrative (the administrator) was made re findings.					
	Medicaid Services Instrument manual assessment is an Reconciliation Act assessment for a completed at leas	e Centers for Medicare and a Resident Assessment al documented, "The Quarterly OBRA (Omnibus Budget on non-comprehensive resident that must be tevery 92 days following the assessment of any type. It is					

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

Event ID:91RI11

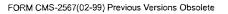
Facility ID: VA0115

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PRINTED: 04/26/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE	& MEDICAID SERVICES			(	MR MO.	0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495261	B. WING	·		04/	19/2018
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEDITAC	E HALL NRSG AND I	DEHAD		1	22 MORVEN PARK ROAD NW		
HERITAG	E HALL NKSG AND I	KCHAD		L	EESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	XIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 638	Continued From pa	ine 28	E 4	638			
1 000		dent's status between	F (	030	l		
		sessments to ensure critical					
	•	al change in a resident's status					
		such, not all MDS items					
		rterly assessment. The ARD					
		ot more than 92 days after the					
		cent OBRA assessment of					
	any type."						
	No further informati	ion was presented prior to exit.					
	#2's quarterly MDS resident's most reco	failed to complete Resident every three months. The ent completed MDS was a ent with an ARD of 11/28/17.					
	8/29/11. Resident #	dmitted to the facility on #2's diagnoses included but shortness of breath, muscle culty in walking.					
		#2's clinical record revealed ompleted MDS was a quarterly of 11/28/17.					
	conducted with RN MDS coordinator). assessments should the assessments should the assessments should the assessment should the assessment should have been conducted with the should have been conducted with RN #1 was made at and asked when the should have been conducted with RN #1 was made at and asked when the should have been conducted with RN assessments with RN assessment with RN assessments with RN assessments with RN assessments with RN assessments with RN assessment with RN assessments with RN assessments with RN assessments with RN assessments with RN assessment with RN assessments with RN assessment with RN assessments with RN assessment	a.m., an interview was (registered nurse) #1 (the RN #1 was asked when MDS d be completed. RN #1 stated hould be completed every ed to clarify what every #1 stated, "Every 91 days." ware of the above findings e next MDS assessment completed. RN #1 stated the heen done on 2/20/18 and t done.					



On 4/19/18 at 9:24 a.m., ASM (administrative



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X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
495261	B. WING		04/19/2018
EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL		X (EACH CORRECTIVE ACTION SHOULD	D BE COMPLETION
e administrator) was made indings.  In was presented prior to exit. In ents  of Assessments. It is not met as evidenced view and clinical record inned that the facility staff accurate MDS (minimum it for six of 33 residents in the idents #10, #91, #95, #23,  inaccurately coded weight in inaccurately coded a indicate in the inaccurately coded a diagnosis on Resident #91's quarterly 3/26/18.  accurately coded a diagnosis on Resident #95's quarterly 3/30/18.  accurately coded a diagnosis on Resident #95's quarterly 3/30/18.	F€	F641 Corrective Action(s): Resident #10 has had their most recent MDS modified to accurately code sector K to reflect no significant weight loss section I to accurately code their curron medical diagnosis. A facility Incident Accident form was completed for this incident.  Resident #91, #95, #23, #42 and #78 had their most recent MDS modified accurately code section I to reflect the resident's current medical diagnosis. facility Incident & Accident form was completed for this incident.  Identification of Deficient Practice(and Corrective Action(s): All other residents may have potential been affected. A 100% audit of all curresident assessments will be completed the MDS Coordinator and/or designed ensure that MDS section I — Active Diagnosis and Section K — Nutrition assessed and coded correctly. All neg findings will be reported to the MDS department for immediate correction. Modification will be completed for each of the material of the mater	tion and ent & have to A s  Illy rrent ed by e to is jative  A ach
	EHAB  EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)  e 29 e administrator) was made indings.  In was presented prior to exit. Inents  of Assessments. Is accurately reflect the  T is not met as evidenced view and clinical record ined that the facility staff I accurate MDS (minimum it for six of 33 residents in the idents #10, #91, #95, #23,  inaccurately coded weight b's quarterly MDS with an iference date) of 11/7/17.  inaccurately coded a	### A BUILD  ### B WING  ### B WING  ### A BUILD  ### B WING  ### B WING  ### B WING  ### A BUILD  ### B WING  ### B WING  ### A BUILD  ### B WING  ### B WING  ### PREFEDED BY FULL  ### C IDENTIFYING INFORMATION)  ### A BUILD  ### B WING  ### PREFEDED BY FULL  ### PREFEDED BY  ### PREFED  ### PRE	A BUILDING  495261  B. WINS  STREET ADDRESS, CITY, STATE, ZIP CODE  122 MORVEN PARK ROAD NW LEESBURG, VA 20176  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  F 641  F 641  F 641  Corrective Action(s): Resident #10 has had their most recen MDS modified to accurately code see K to reflect no significant weight loss section I to accurately code their curre medical diagnosis. A facility Incident view and clinical record inned that the facility staff accurate MDS (minimum it for six of 33 residents in the idents #10, #91, #95, #23, inaccurately coded weight vis quarterly MDS with an ference date) of 11/7/17.  inaccurately coded a dic disorder on Resident #10's in ARD of 1/22/18.  accurately coded a diagnosis on Resident #91's quarterly 3/26/18.  accurately coded a diagnosis on Resident #95's quarterly 3/30/18.  alield to accurately code nosis on the quarterly MDS  street ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW LEESBURG, VA 20176  PROVIDER'S PLAN OF CORRECTION SHOULD (CROSS-REFERENCED TO THE APPROP DEFICIENCY)  PROVIDER'S PLAN OF CORRECTION SHOULD (CROSS-REFERENCED TO THE APPROP DEFICIENCY)  F 641  Corrective Action(s): Resident #10 has had their most recen MDS modified to accurately code section I to reflect the resident suspanses will be completed for this incident.  Identification of Deficient Practice( and Corrective Action(s): All other residents may have potential been affected. A 100% audit of all curresidents suspanses will be complete the MDS Coordinator and/or designed ensure that MDS section I — Active Diagnosis and Section K — Nutrition assessed and code correctly. All neg findings will be reported to the MDS department for immediate correction. Modification will be completed for ediscrepancy identified on the most cu MDS.

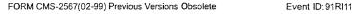
PRINTED: 04/26/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	·			OIMP 140	<del>J. 0330-039 I</del>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			ATE SURVEY OMPLETED				
		495261	B. WING			0.	4/19/2018
NAME OF F	PROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
HEDITAC	E HALL NRSG AND	DEHAR		1	122 MORVEN PARK ROAD NW		
HEKHAC	L HALL MIGO AND	KLIAD		L	LEESBURG, VA 20176		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 641	C4:	20	, 	044			;
F 0411	Continued From pa		F	641	Systemic Change(s): The Resident Interdisciplinary Care	Team	
	(assessment refere	ence date) of 02/02/18.			have been inserviced by the Region		
	5. The facility staff	inaccurately code Resident			Nurse consultant on the proper		
		agnosis of psychotic disorder			assessment and coding of all areas		
	on the annual MDS	with an ARD of 2/16/18.			MDS to include sections I and K of MDS. All comprehensive MDS's a		
	C. The feelih steff	innerwatch, and ad Caption 1			quarterly MDS's will now be revie		
	Active Diagnoses f	inaccurately coded Section I -			each week according to the MDS		
	Active Diagnoses i	or resident #15.	1		schedule by the RCC and/or DON		-
The findings include:		ensure the accuracy and integrity o resident data.					
	loss on Resident # ARD (assessment #10 was a 1/20/15. Resident were not limited to behavioral disturbation chronic kidney disercent MDS, a quatof 4/16/18, coded to severely impaired.  Resident #10's quatof 1/7/17 documented of 5% or more in the more in the last 6 masses.	aff inaccurately coded weight 10's quarterly MDS with an reference date) of 11/7/17.  admitted to the facility on #10's diagnoses included but unspecified dementia (1) with nce, anxiety disorder and ease. Resident #10's most reterly assessment with an ARD he resident's cognition as arterly MDS with an ARD of ed, "K0300. Weight Loss. Loss the last month or loss of 10% or months- 2. Yes, not on ed weight-loss regimen."			Monitoring: The DON and RCC are responsible monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS of to monitor for compliance. All neg findings from the audits will be rept to the DON and RCC at the time of discovery for immediate correction Aggregate findings will be reported Quality Assurance Committee monfor review, analysis, and recommendations for change in fact policy, procedure, and/or practice. Completion Date: May 30, 2018	alendar ative ported f to the	
:	the resident's weight and 98 pounds on percent in one mor Resident #10's clin resident's weight w	t #10's clinical record revealed on twas 98.5 pounds on 10/5/17 11/5/17 (only a loss of 0.51 oth). Further review of ical record revealed the as 106.3 pounds on 5/1/17 11/5/17 (only a loss of 8.47					

percent in six months).

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- Land I I have	NO I ON WILDIOANL	G WILDIOMID SERVICES	<del></del>		CIVID	NO. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		DATE SURVEY COMPLETED
		495261	B. WING	<b>.</b>		04/19/2018
	PROVIDER OR SUPPLIER  GE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	· · · · · · · · · · · · · · · · · · ·	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 641	conducted with RN MDS coordinator). the above concern. weight had been stresident had preser loss, RN #1 stated, Resident #10's MD. On 4/18/18 at 5:10 staff member) #1 (the director of nursabove findings.  Chapter three of the Medicaid Services Instrument manual LossCoding Instrunknown if the residual weight loss of 5% of 10% or more in the about prior weight in not on physician-presif the resident has ef 5% or more in the pthe last 180 days, a planned and prescri	ge 31 p.m., an interview was (registered nurse) #1 (the RN #1 was made aware of RN #1 stated Resident #10's able. When asked if the nted with a significant weight "No." RN #1 confirmed S was inaccurately coded. p.m., ASM (administrative he administrator) and ASM #2 sing) were made aware of the e Centers for Medicare and Resident Assessment documented, "K0300: Weight actionsCode 0, no or dent has not experienced or more in the past 30 days or last 180 days or if information on not availableCode 2, yes, escribed weight-loss regimen: experienced a weight loss of last 30 days or 10% or more in not the weight loss was not libed by a physician."	F	641		
	symptoms caused the brain. It is not a specific dementia may not be do normal activities eating. They may be problems or control personalities may clear.	e name for a group of by disorders that affect the ecific disease. People with the able to think well enough to a such as getting dressed or lose their ability to solve their emotions. Their mange. They may become get that are not there." This				





Facility ID: VA0115

If continuation sheet Page 32 of 53



	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION ING			SURVEY PLETED
		495261	B. WING			04/	19/2018
**	PROVIDER OR SUPPLIER  GE HALL NRSG AND			STREET ADDRESS, CITY, STATE, ZIF 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	ODE .		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD I HE APPROPR	BE	(X5) COMPLETION DATE
F 641	information was obhttps://medlineplus  1. b. The facility stadiagnosis of psychoquarterly MDS with Section I "Active Diquarterly MDS with documented, "I. Active Diquarterly MDS with documented with Rosewick and Indianates Indianates and Indianates Indianates and Indianates Ind	ottained from the website: .gov/dementia.html  aff inaccurately coded a otic disorder on Resident #10's an ARD of 1/22/18.  itagnoses" of Resident #10's an ARD of 1/22/18 tive Diagnoses in the last 7 at apply." A check was coded chotic Disorder (2)" Review clinical record (including an notes and psychiatry notes) sident #10 presented with a (or psychotic behaviors such or delusions).  p.m., an interview was (registered nurse) #1 (the RN #1 was asked to research hy Resident #10's MDS coded ring a psychotic disorder.  p.m., RN #1 stated Resident having a psychotic disorder ant had a diagnosis of	F	341			

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION ING			E SURVEY PLETED
	·	495261	B. WING			04/-	19/2018
	OVIDER OR SUPPLIER  HALL NRSG AND	REHAB		STREET ADDRESS, CITY, ST. 122 MORVEN PARK ROAD LEESBURG, VA 20176	) NW	<u> </u>	10/20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ED TO THE APPROPE ICIENCY)	BE	(X5) COMPLETION DATE
F 641 C b read with the control of t	Continued From pare havior like sundo esident with deme are not related to pare haviors we have a saked to present to be haviors we have a sked to present to be haviors we have a saked to present to be haviors we have findings.  On 4/18/18 at 5:10 taff member) #1 (to the director of nurse have findings.  On 4/19/18 at 8:30 Resident #10's clinical sections are pare haviors of psychotic features. Chapter three of the metric of the metric of the havior of the hav	age 33 bwners." RN #1 was asked if a ntia could have behaviors that sychosis. RN #1 stated, "It all nose behaviors are." RN #1 ent evidence that Resident ere related to psychosis.  p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the a.m., RN #1 stated review of ical record only revealed such as yelling or hitting, with es.  e Centers for Medicare and Resident Assessment documented, "Section I: ESSteps for Assessment1. The disease conditions in this hysician-documented nurse practitioner, physician I nurse specialist if allowable re laws) in the last 60 days elationship to the resident's tatus, cognitive status, mood medical treatments, nursing of death during the 7-day	F 6	DEFI			
		on was presented prior to exit.					
S	ymptoms caused b	e name for a group of by disorders that affect the ecific disease. People with					

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CENTE	KS FOR MEDICARE	& MEDICAID SERVICES			OIVID IN	<i>J.</i> 0936-039 I		
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495261	B. WING		0,	4/19/2018		
	PROVIDER OR SUPPLIER  GE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE BE APPROPRIATE	(X5) COMPLETION DATE		
F 641	do normal activities eating. They may problems or contro personalities may cagitated or see thir information was ob-	age 34 be able to think well enough to s, such as getting dressed or lose their ability to solve I their emotions. Their change. They may become ags that are not there." This tained from the website: .gov/dementia.html	F	641				
	disorders that cause perceptions. Peop with reality. Two of delusions and hallous beliefs, such as this against you or that messages. Hallucis such as hearing, se is not there." This the website: https://vsearch.nlmmeta?v%3Aprojectmedlineplus-bundle	rders are severe mental se abnormal thinking and le with psychoses lose touch of the main symptoms are acinations. Delusions are false nking that someone is plotting the TV is sending you secret inations are false perceptions, being, or feeling something that information was obtained from an inih.gov/vivisimo/cgi-bin/query-medlineplus&v%3Asources=e&query=psychotic+disorder&_059850956.1524141461-1391						
	Resident #91 was a 10/2/14. Resident were not limited to behavioral disturbadisease and high b most recent MDS, ARD of 3/26/18, co	inaccurately coded a diagnosis er on Resident #91's quarterly of 3/26/18.  admitted to the facility on #91's diagnoses included but unspecified dementia with Ince (1), chronic kidney lood pressure. Resident #91's a quarterly assessment with an Ided the resident's cognitive Ision-making as moderately						

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impaired. Section I "Active Diagnoses" of

Event ID: 91RI11

Facility ID: VA0115

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY PLETED
		495261	B. WING		04/	19/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
UEDITA	GE HALL NRSG AND	DEHAR		122 MORVEN PARK ROAD NW		
DEKHA	SE HALL MIGG AND	(LIPE)		LEESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 641	Diagnoses in the la apply." A check wa	S documented, "I. Active st 7 days- Check all that is coded beside "I5950.	F6	41		
	#91's clinical record physician notes and reveal Resident #9	(2)" Review of Resident d (including diagnoses, d psychiatry notes) failed to 1 presented with a psychotic tic behaviors such as elusions).				
	conducted with RN MDS coordinator). and then explain w	p.m., an interview was (registered nurse) #1 (the RN #1 was asked to research ny Resident #91's MDS coded ing a psychotic disorder.				
	#91 was coded as a because the reside unspecified demendisturbance. When source used to class behavioral disturba	p.m., RN #1 stated Resident having a psychotic disorder in had a diagnosis of tia with behavioral in RN #1 was asked for her asify unspecified dementia with ince as a psychotic disorder, revious boss taught her to.				
	conducted with RN resident could have disturbance and no #1 stated, "If they he they usually have p behavior like sundo resident with demerare not related to pe depends on what the was asked to prese	p.m., another interview was #1. RN #1 was asked if a dementia with behavioral tresent with psychosis. RN ave dementia with behaviors sychosis that is causing the winers." RN #1 was asked if a nitia could have behaviors that sychosis. RN #1 stated, "It all nose behaviors are." RN #1 ant evidence that Resident re related to psychosis.				

On 4/18/18 at 5:10 p.m., ASM (administrative

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CENTERS FOR MEDICARE & MEDICAID SERVICES			·			NAR NO. 0838-03	71
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495261	B. WING	;		04/19/2018	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
UEDITAC	THALL NOCC AND	DEUAD		1:	22 MORVEN PARK ROAD NW		
HERITAG	SE HALL NRSG AND	KERAD		L	EESBURG, VA 20176		j
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLÉTIC	N
F 641	Continued From pa	ge 36	F	641			
	staff member) #1 (t	he administrator) and ASM #2 sing) were made aware of the					
	Resident #91's clini	a.m., RN #1 stated review of ical record only revealed such as yelling or hitting, with es.					
	No further informati	on was presented prior to exit.					
	symptoms caused brain. It is not a sp dementia may not be do normal activities eating. They may be problems or control personalities may cagitated or see thin	e name for a group of by disorders that affect the ecific disease. People with be able to think well enough to , such as getting dressed or ose their ability to solve their emotions. Their hange. They may become gs that are not there." This tained from the website: gov/dementia.html					
	disorders that cause perceptions. Peopl with reality. Two of delusions and hallubeliefs, such as thir against you or that messages. Hallucing such as hearing, see is not there." This if the website: https://vsearch.nlm.meta?v%3Aprojectmedlineplus-bundle	ders are severe mental e abnormal thinking and e with psychoses lose touch the main symptoms are cinations. Delusions are false aking that someone is plotting the TV is sending you secret nations are false perceptions, seing, or feeling something that information was obtained from nih.gov/vivisimo/cgi-bin/query= medlineplus&v%3Asources= &query=psychotic+disorder&_ 059850956.1524141461-1391					

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20270.1477942321

Event ID:91RI11

Facility ID: VA0115

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### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495261	B. WING	i	noncontrata anno anno anno anno anno anno anno a	04/19/2018				
NAME OF I	PROVIDER OR SUPPLIER		**************************************	STR	EET ADDRESS, CITY, STATE, ZIP CODE					
HERITAC	GE HALL NRSG AND	REHAB		l	MORVEN PARK ROAD NW ESBURG, VA 20176					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION				
F 641	Continued From pa	ge 37	F	641						
	of psychotic disorded MDS (minimum data (assessment refered assessment resident assessment resident apply." A check was psychotic Disorder #95's clinical record physician notes and reveal Resident #9	admitted to the facility on #95's diagnoses included but unspecified dementia with nce, high blood pressure and #95's most recent MDS, a ent with an ARD of 3/30/18, s cognition as severely "Active Diagnoses" of S documented, "I. Active st 7 days- Check all that is coded beside "I5950.  (2)" Review of Resident d (including diagnoses, d psychiatry notes) failed to 5 presented with a psychotic tic behaviors such as								
	conducted with RN MDS coordinator). and then explain w the resident as hav On 4/18/18 at 3:28 #95 was coded as because the reside unspecified demen	p.m., an interview was (registered nurse) #1 (the RN #1 was asked to research by Resident #95's MDS coded ing a psychotic disorder.  p.m., RN #1 stated Resident having a psychotic disorder in thad a diagnosis of tia with behavioral a RN #1 was asked for her								

source used to classify unspecified dementia with behavioral disturbance as a psychotic disorder, RN #1 stated her previous boss taught her to.

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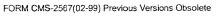
CENTERS FOR MEDICARE & MEDICAID SERVICES			-		C	<u>IMR NO</u>	<u>. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION		TE SURVEY MPLETED
		495261	B. WING			04	/19/2018
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		***************************************
HERITAG	SE HALL NRSG AND I	REHAB			MORVEN PARK ROAD NW		
				LEE	SBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
	conducted with RN resident could have disturbance and nor #1 stated, "If they he they usually have personal to be behavior like sundoresident with demerare not related to personal to be depends on what they was asked to prese #95's behaviors were On 4/18/18 at 5:10 staff member) #1 (the director of nursabove findings.  On 4/19/18 at 8:30 are Resident #95's clinior regular behaviors no psychotic feature. No further information (1) "Dementia is the symptoms caused be brain. It is not a specific dementia may not be do normal activities, eating. They may be problems or control personalities may chagitated or see thing information was obtain.	p.m., another interview was #1. RN #1 was asked if a e dementia with behavioral of present with psychosis. RN have dementia with behaviors sychosis that is causing the owners." RN #1 was asked if a notia could have behaviors that sychosis. RN #1 stated, "It all nose behaviors are." RN #1 ent evidence that Resident are related to psychosis.  p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the a.m., RN #1 stated review of ical record only revealed such as yelling or hitting, with es.  ion was presented prior to exit. It is name for a group of by disorders that affect the ecific disease. People with the able to think well enough to a such as getting dressed or ose their ability to solve their emotions. Their hange. They may become gs that are not there." This tained from the website:	F 6	41	DEFICIENCY)		
	https://medlineplus.g						

(2) "Psychotic disorders are severe mental disorders that cause abnormal thinking and

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		TE SURVEY MPLETED	
		495261	B. WING			04	/19/2018	
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	-		
	SELLALL NIDOC AND	DELLAD		122	MORVEN PARK ROAD NW			
HERITA	GE HALL NRSG AND	REHAB		LEE	ESBURG, VA 20176			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 6/1	Continued From pa	ogo 30	F 6	2/1				
1 041	•		rt	)4				
		le with psychoses lose touch the main symptoms are						
	-	icinations. Delusions are false						
		nking that someone is plotting						
		the TV is sending you secret						
		nations are false perceptions,						
		eeing, or feeling something that						
		information was obtained from						
	the website:						1	
		.nih.gov/vivisimo/cgi-bin/query-						
		=medlineplus&v%3Asources= e&query=psychotic+disorder&	F					
		059850956.1524141461-1391						
	20270.1477942321							
	4. The facility staff	failed to accurately code						
		gnosis on the quarterly MDS						
		) assessment with an ARD						
		ence date) of 02/02/18.						
	Resident # 23 was	admitted to the facility on						
		loses that included but were						
		ntia with behavioral						
	disturbances (1), m	ajor depressive disorder (2),						
	osteoporosis (3) an	d dysphagia (4).	:					
	Resident # 23's mo	st recent MDS (minimum data						
		sessment with an ARD						
		ence date) of 02/02/18 coded		:			. [	
		eing severely impaired of	-	:				
	, •	g daily decisions. Resident #	Į.					
		equiring extensive assistance						
		endent of one staff member for ing. Review of "Section E	\$					
		ing. Review of Section E						
		ehavioral symptoms. Under						
		agnoses" it documented, "I.					İ	
		the last 7 (seven) days -		:			To a second seco	



Check all that apply." Under "Psychiatric/Mood



Facility ID: VA0115

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	OMB NO. 0938-039					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED		
		495261	B. WING		04	/19/2018		
	PROVIDER OR SUPPLIER  GE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, 2 122 MORVEN PARK ROAD NW LEESBURG, VA 20176				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 641	identifying "I5950. If than schizophrenia than schizophrenia The POS (physicial 2018 documented, dementia with behalf on 04/19/18 at 10: conducted with RN (minimum data set about the diagnosis documented on Reassessment with adate) of 02/02/18, If dementia with behalf psychiatric disorder On 04/19/18 at 12: staff member) # 1, 2, the director of nuabove concerns.  No further informate References: (1) Psychological sabnormalities are of characteristics of disymptoms such as psychosis, agitation and sleep disturbare 90% of patients with behavioral disorder interactions between psychological sympabnormalities. This	Is a check mark in the box Psychiatric Disorder (other )."  In's order sheet) dated April "Dx (diagnosis): Unspecified avioral disturbance."  45 a.m., an interview was (registered nurse) # 1, MDS ) coordinator. When asked is of psychiatric disorder sident # 23's quarterly MDS in ARD (assessment reference RN # 1 stated, "I thought of avioral disturbances as a it."  On p.m. ASM (administrative the administrator, and ASM # ursing, were made aware of the ion was provided prior to exit.  In ymptoms and behavioral formous and prominent formentia. They include for depression, anxiety in, aggression, disinhibition, forces. Approximately 30% to h dementia suffer from such is. There are complex		641				
	behavioral disorder interactions betwee psychological symp	s. There are complex en cognitive deficits, otoms, and behavioral						

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https://www.ncbi.nlm.nih.gov/pmc/articles/PMC31

Event ID: 91RI11

Facility ID: VA0115

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

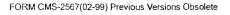
PRINTED: 04/26/2018 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						ONI DIVIC	. 0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495261	B. WING			04	/19/2018
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
LIFETA	SELLALL NEGO AND	DELLAD		122 N	MORVEN PARK ROAD NW		
HERITAG	GE HALL NRSG AND	KENAB		LEE	SBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETION DATE
F 641	Continued From pa	nge 41	F6	641			
	when feelings of sa frustration get in the period of time. It als works. This inform website: https://medlineplus	on is a mood disorder. It occurs idness, loss, anger, or e way of your life over a long so changes how your body ation was obtained from the .gov/ency/article/000945.htm.					
	website:	ation was obtained from the n.gov/medlineplus/osteoporosi					
	obtained from the whttps://www.nlm.nihsorders.html. 5. The facility staff #42 as having a dia on the annual MDS	sorder. This information was vebsite: n.gov/medlineplus/swallowingdi inaccurately code Resident agnosis of psychotic disorder i (minimum data set) with an reference date) of 2/16/18.					
	diagnoses of but no disease, anxiety dis depression, migrain dementia with beha pressure. The mos Set) was an annual (Assessment Refer resident was coded ability to make daily was coded as requ	admitted on 4/14/17 with the of limited to cerebral vascular sorder, insomnia, falls, nes, dysphagia, osteoarthritis, aviors, and high blood of recent MDS (Minimum Data assessment with an ARD rence Date) of 2/16/18. The I as moderately impaired in a life decisions. The resident iring extensive assistance with e; limited assistance with ling; supervision for					

ambulation, eating, and toileting; and as

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-			<u>)MB NO. (</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495261	B. WING			04/1	9/2018
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	***************************************	
HERITAG	E HALL NRSG AND	REHAB			2 MORVEN PARK ROAD NW		
				LE	ESBURG, VA 20176		
(X4) ID - PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	× :	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 641	Continued From pa	an 42	ге	41			
1 041	<u>-</u>	-	ro	411			
	incontinent of bowe	and bladder.					
	Active Diagnoses, or Disorder" the box n	ve MDS revealed in Section I, under "Psychiatric/Mood ext to I5950 "Psychotic than schizophrenia)" was					
		cal record failed to reveal a ted diagnosis of psychotic					
	#1 (Registered Nur that because the re "Unspecified deme- disturbance [2]", sh supervisor to code	e was taught by a previous those residents as psychotic. as told wrong and the MDS					
		I a.m., the Administrator was findings. No further ovided.					
	is a loss of ego bou in reality testing with hallucinations. Information obtaine https://www.ncbi.nlr %22psychotic%20d erms%5D&cmd=De	n.nih.gov/mesh/?term= lisorders%22%5BMeSH%20T etailsSearch					
		nentia with behavioral ological symptoms and					



behavioral abnormalities are common and

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Facility ID: VA0115

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495261	B. WING		04/19/2018
	PROVIDER OR SUPPLIER  E HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP CO 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	<del></del>
(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 COR IX (EACH CORRECTIVE ACTION	I SHOULD BE COMPLÉTION
F 641	include symptoms psychosis, agitation and sleep disturban 90% of patients with behavioral disorder Information obtained https://www.ncbi.nl 81717/  6. The facility staff Section I - Active Exercised HT8 was 1/31/13 with diagnoral limited to: unspecificant symptoms of the symptoms of th	eristics of dementia. They such as depression, anxiety n, aggression, disinhibition, nces. Approximately 30% to the dementia suffer from such rs.		641	
	assessment, a qua assessment refere resident as having memory difficulties impaired to make of Resident #78 was Diagnoses as having (Disorders in which boundaries or a gro testing with delusion (1).  The clinical record documented evided psychotic disorder, for April 2018 failed diagnosis of a psychosic	IDS (minimum data set) Interly assessment, with an ince date of 4/19/18, coded the both short and long-term and as being severely daily cognitive decisions. Incoded in Section I - Active ing a Psychotic Disorder in there is a loss of ego in the end in t			

with behavioral disturbances.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		OMB NO	D. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		ATE SURVEY DMPLETED
		495261	B. WING		0,	4/19/2018
	PROVIDER OR SUPPLIER  BE HALL NRSG AND	REHAB		STREET ADDRESS, CITY, STATE, ZIP 122 MORVEN PARK ROAD NW LEESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 641	Continued From pa	nge 44	F 6	41		
		ress notes going back to vidence documentation of a				
	nurse) #1, the MDS p.m. When asked was having a psychology was taught by the president has a diagonic with behavioral distribution of the psychotic disorder.	onducted with RN (registered 5 nurse, on 4/18/18 at 3:40 why(Resident #78) was coded the disorder, RN #1 stated, "I previous MDS nurse that if a nosis of unspecified dementia urbance I was to code it as a When asked if unspecified avioral disturbance is a RN #1 stated she would get by team.				
	4:20 p.m. and press Neurology" form 20 by the survey team was appropriate. For documentation of the	his surveyor on 4/18/18 at ented a paper "Frontiers in 12. The article was reviewed members and did not feel it 2N #1 was asked to locate any ne resident having psychotic pecified dementia with nces.				
	On 4/19/18 at 8:30 resident had regula documentation of p					
		e on 4/19/18 at approximately of any psychiatry/psychology one were provided.				
	#3, the corporate not the facility staff use	strative staff member (ASM) urse, informed this surveyor s the RAI (resident instrument ting the MDS assessments.				



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CENTERS FOR MEDICARE	A MEDICAID SERVICES					1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		E SURVEY PLETED
	495261	B. WING		NAME OF THE PROPERTY OF THE PR	04/	19/2018
NAME OF PROVIDER OR SUPPLIER		3	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
	DELLAD		12:	2 MORVEN PARK ROAD NW		
HERITAGE HALL NRSG AND	KEHAB		LE	ESBURG, VA 20176		
DREETY (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
concern on 4/19/18  (1) This information	was made aware of the above	F :	641			
following website: https://www.ncbi.nl %22psychotic%20 erms%5D&cmd=D F 812 Food Procurement SS=D CFR(s): 483.60(i)( §483.60(i) Food sa The facility must - §483.60(i)(1) - Pro approved or considerate or local author (i) This may include from local produce and local laws or re (ii) This provision of facilities from using gardens, subject to safe growing and form consuming form con	m.nih.gov/mesh/?term= disorders%22%5BMeSH%20T etailsSearch ,Store/Prepare/Serve-Sanitary 1)(2) dety requirements.  cure food from sources dered satisfactory by federal, orities. e food items obtained directly rs, subject to applicable State egulations. does not prohibit or prevent g produce grown in facility o compliance with applicable food-handling practices. does not preclude residents bods not procured by the facility.  re, prepare, distribute and rdance with professional	F	812:	Corrective Action(s):  The Dietary Aide observed passing do bowls improperly in the dining room observation has been inserviced on the proper procedure for wearing and changing gloves during food preparate and delivery. A Facility Incident & Accident form has been completed for this incident.  Identification of Deficient Practices Corrective Action(s): All other residents may have been potentially affected. The Food Service Manager or designee will monitor the line and dining room meal pass proceduring all meal services for 3 days to identify any negative findings. All negative findings will be corrected at of discovery. A Risk Management Incident Report will be completed for each negative findings will result in appropriate disciplinary action.	e ion r e & e tray ss time	

Facility ID: VA0115

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CLIVILI	O I OIL MILDIONICE	G MEDIONID SERVICES				AVID INO.	. 0000-000	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE SURVEY COMPLETED	
		495261	B. WING	·		04/	19/2018	
NAME OF F	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1:	22 MORVEN PARK ROAD NW			
HERITAG	E HALL NRSG AND I	REHAB		i	EESBURG, VA 20176		:	
i	0.000.000.000	THE STATE OF DEPLOYED		L				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPROVIDENCE) DEFICIENCY)		D BE	(X5) COMPLETION DATE		
					Systemic Change(s):			
F 812	Continued From pa	ge 46	F	812				
-	The facility staff fail	ed to change gloves between			Current facility policy & procedure ha	LS		
		art and serving residents'			been reviewed and no changes are		•	
	desserts in the mai				warranted at this time. The consulting			
	accounts in the man	rranning room.			Registered Dietician will inservice the	;		
	The findings include	a•			CDM and dietary staff on the proper			
:	The munigs module	<del>5</del> .			preparing, storing and distribution of			
	On 04/17/40 at 44:0	20 c m on observation of the	t t		under sanitary conditions, as well as the			
		20 a.m., an observation of the	i i		policy and procedure for proper glove			
		nducted in the main dining	usage and hand washing.					
		staff member) # 1, dietary	:					
		pushing a serving cart			Monitoring:			
		ng room while wearing			The CDM is responsible for maintaining			
		The serving cart had two			compliance. The Administrator and/o			
		e shelves contained			Food service manager will complete 3			
		covered dessert bowls			meal pass audits weekly to monitor ar			
		ears. OSM # 1 stopped at			maintaining compliance. The results	31		
		able, pick up a bowl of pears	:		these audits will be reported to the			
		ploves she use to push the			Quality Assurance Committee for rev			
		aced the bowl of pears in front			analysis, & recommendations for char	ige		
	of each resident at	the table. Further observation			in facility policy, procedure, and/or			
	of OSM # 1 picking	up the bowls of pears			practice.			
	revealed her thumb	was placed on the inside lip			Completion Date: May 30, 2018			
		f 1 was observed serving 25						
		sidents in the dining room in						
	this manner.	G						
	•							
	On 04/17/18 at 1:08	3 p.m., an interview was			•			
	conducted with OSI	M # 1, dietary aide. When			•			
		wearing gloves when serving	:		•			
		1 stated, "It's so you don't			•			
		food." When asked how the	:					
		owls should be handled OSM						
		sing an empty bowl and						
		mb on the top inside edge of						
		ked if it was appropriate to	;					
					•			
		ng the same-gloved hands						
		ush the serving cart OSM #1						
	stated, "I don't think	. SO.			•			

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On 04/17/18 at 1:19 p.m., an interview was

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Facility ID: VA0115

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			***************************************		T T	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILL		INSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495261	B. WING		MANAGERI (MANAGERI MANAGERI M	04/19/2018	
NAME OF PROVIDER OR SUPPLIER		L	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
			122 M	IORVEN PARK ROAD NW		
HERITAGE HALL NRSG AND	REHAB		LEES	SBURG, VA 20176		
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
When asked to desigloves for meal ser resident's food is no hands. You should hands for the same observation of OSM dining room, OSM have changed her residents.	nge 47 M # 2, dietary manager. scribe the purpose for wearing rvice, OSM # 2 stated, "So the ot touched with the staff's bare not use the same gloved e task." When informed of the M # 1 during lunch in the main # 2 stated OSM # 1 should gloves before serving the "Safety and Sanitation	F	812:		·	
-Section E. IX. Glo Gloves will be worr food preparation an Proper use of glove whenever you char being worked with, work station."  On 04/18/18 at 5:0 staff member) # 1,	ove Use" documented, "Policy: in to maintain safe and sanitary and service. PROCEDURE: 3. es: d) Change gloves age an activity, the type of food or whenever you leave the  5 p.m. ASM (administrative the administrator, and ASM # ursing, were made aware of the					
F 842 Resident Records SS=D CFR(s): 483.20(f)(5) \$483.20(f)(5) Resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of	5), 483.70(i)(1)-(5)  dent-identifiable information.  t release information that is		842	F842 Corrective Action(s): Resident #336's attending physician been notified that the facility staff fa to accurately document that the resid was receiving oxygen therapy on the Nursing daily skilled assessment. A facility Incident & Accident form habeen completed for this incident.	iled dent	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495261	B. WING		,	04/19/2018	
NAME OF I	PROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STREET ADDRESS, CITY, STATE, ZIP CO		***************************************	
				122 MORVEN PARK ROAD NW			
HERITAC	SE HALL NRSG AND	REHAB		LEESBURG, VA 20176			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	HOULD BE	(X5) COMPLETION DATE	
F 842	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIVE ACTION SET (EACH CORRECTIVE ACTION SET CROSS-REFERENCED TO THE AFRE DEFICIENCY)  Identification of Deficient Pract Corrective Action(s): All other Skilled residents may had potentially been affected. A 100% of all current Medicare Part A Skilled Resident's Medical Records will be conducted by the DON, ADON, a Unit Managers to identify resident risk. All negative findings will be as applicable at time of discovery. facility Incident & Accident form completed for each negative finding.  Systemic Change(s): The facility policy and procedure been reviewed and no changes are warranted at this time. All licenses nursing staff will be inserviced by DON on the clinical documentation standards per facility policy and procedure. This training will inclust and procedure. This training will inclust and ards for maintaining accurate medical records and clinical documentation to include Nursing Skilled assessment and departmen notes according to the acceptable professional standards and practice Monitoring:		has e d d the on de the e g Daily ntal ees.  daining nd/or rt audits edule to negative ected at a cation ts of Quality s and ncility		
	(ii) Five years from the date of discharge when						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495261	B. WING		04/19/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND REHAB				STREET ADDRESS, CITY, STATE, Z 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFID TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 842	Continued From pa	age 49	· F8	42	
		ment in State law; or years after a resident reaches ate law.			
	(i) Sufficient inform (ii) A record of the (iii) The compreher provided; (iv) The results of a and resident review determinations cor (v) Physician's, nur professional's prog (vi) Laboratory, rad services reports as This REQUIREME by: Based on staff inte review, it was determination a complet	nducted by the State; rse's, and other licensed			
	"Nursing Assessme	led to ensure the facility's ents" dated 04/16/18 and y reflected Resident # 336's			
	The findings includ	e:			
	05/04/17 and a rea diagnoses that incl fractured femur (1) hypertension (3) at	s admitted to the facility on dmission on 04/13/18 with uded but were not limited to , cerebral infarction (2), rial fibrillation (4), benign ia (5) and anemia (6).			
	Resident # 336's ad	dmission MDS (minimum data			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495261	B. WING			04/19/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND REHAB				ET ADDRESS, CITY, STATE, ZIP CODE MORVEN PARK ROAD NW SBURG, VA 20176			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 842	Observations of R of the survey reve at two liters per m  The POS (physicia 336 dated April 20 (two) liters via (by continuous. DX (d breath). Date Ordo4/16/18."  The "Nursing Daily Resident" for Resident" for Resident" for Resident ordered oxygen.  On 04/19/18 at 7:3 conducted with LF 3. When asked at The POS dated Application of the "Nursing Daily at LPN # 3 then provof the "Nursing Daily at LPN # 3 the	at the time of the survey. esident # 336 during the days aled he was receiving oxygen inute by nasal cannula.  an's order sheet) for Resident # 18 documented, "Oxygen at 2 NC (nasal cannula) iagnosis): SOB (shortness of ered: 04/16/18. Start Date:  Assessment Of Skilled dent # 336 dated 04/16/18 and document the physician  B5 a.m., an interview was N (licensed practical nurse) # bout the discrepancy between oril 2018 and the "Nursing Daily cilled Resident" for Resident # 8 and 04/17/18, LPN # 3 stated ssessments were incorrect. ided this surveyor with copies idy Assessment Of Skilled dent # 336 dated 04/16/18 and review of the assessments documenting Resident # 336's oxygen. LPN # 3 stated, beted this morning they correctly t's current status and the		342			

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Event ID: 91RI11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	495261	B. WING			04/19/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND REHAB			STREET ADDRESS, CITY, STATE, ZIP C 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	ODE	<b>V</b>	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX (EACH CORRECTIVE ACTION	N SHOULD	BE COMPLETION	
assessment each of assessment is com "Nursing Daily Assed dated 04/16/18 and ASM # 2 stated the accurate concernin oxygen.  On 04/19/18 at 12:0 staff member) # 1, 2, the director of nuabove concerns.  No further information in the state of	Is complete the nursing daily day until the comprehensive inpleted." After reviewing the essment Of Skilled Resident" dou/17/18 for Resident # 336, assessments were not ing the physician's ordered.  On p.m. ASM (administrative the administrator, and ASM # ursing, were made aware of the dien was provided prior to exit.  The thigh bone. You may have an open reduction internal gery, your surgeon will make a facture. This information was website:  The blood flow to a part of the die is sometimes called a "brain ow is cut off for longer than a rain cannot get nutrients and can die, causing lasting mation was obtained from the decision. This information was website:  This information was website:  This information was website:		842			
https://www.nlm.nih.gov/medlineplus/highbloodpr						

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Facility ID: VA0115

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED	
		495261	B. WING	·		04/19/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	ZIP CODE	VIII.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	EX (EACH CORRECTIVE ACT	TION SHOULD BE THE APPROPRIA		
F 842	heartbeat. This inf the website: https://www.nlm.nif on.html.  (5) An enlarged pro obtained from the w https://www.nlm.nif statebph.html.  (6) Low iron. This in the website:	the speed or rhythm of the formation was obtained from h.gov/medlineplus/atrialfibrillati	FE	842			

State of Virginia (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING \_ B. WING 04/19/2018 495261 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 122 MORVEN PARK ROAD NW HERITAGE HALL NRSG AND REHAB LEESBURG, VA 20176 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG TAG DEFICIENCY) F 000 Initial Comments F 000 An unannounced biennial State Licensure Inspection was conducted 4/17/18 through 4/19/18. Corrections are required for compliance with 42CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. F 001 12 VAC 5-371-340 The census in this 164 certified bed facility was Cross Reference to F 812 139 at the time of the survey. The survey sample consisted of 30 current residents reviews Cross Reference POC for F 812 (Residents #9, 335, 124, 1, 62, 6, 42, 88, 10, 64, 91, 112, 52, 57, 84, 102, 65, 22, 83, 95, 2, 334, 12 VAC 5-371-360 130, 78, 77, 336, 110, 23, 36, and 29) and three Cross Reference to F 842 closed record reviews (Residents #133, 134, and 135). Cross Reference POC for F 842 12 VAC 5-371-110. Management and F 001 F 001 Non Compliance Administration Cross Reference to F 625 The facility was out of compliance with the following state licensure requirements: Cross Reference POC for F 625 This RULE: is not met as evidenced by: 12 VAC 5-371-140. Policies and 12 VAC 5 - 371 - 340 cross references to F 812 procedures Cross Reference to F622, F623, and F625 12 VAC 5 - 371 - 360 - cross references to F 842 Cross Reference POC for F622, F623, and 12VAC5-371-110. Management and F625 administration Cross reference to F625 12 VAC 5-371-150. Resident Rights Cross Reference to F622, F623, and F625 12VAC5-371-140. Policies and procedures Cross Reference POC for F622, F623, and Cross reference to F622, F623, and F625 F625 12VAC5-371-150. Resident rights Cross reference to F622, F623, and F625 12 VAC 371-250. Resident Assessment and Care Planning Cross Reference to F641 12VAC5-371-250. Resident assessment and care planning Cross Reference POC for F641 Cross reference to F641

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

TITLE

(X6) DATE

PRINTED: 04/26/2018 FORM APPROVED

State of Virginia STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A. BUILDING 495261 04/19/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 122 MORVEN PARK ROAD NW HERITAGE HALL NRSG AND REHAB LEESBURG, VA 20176 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 001 Continued From Page 1 F 001 12 VAC 5-371-360. Clinical Records Cross Reference to F622 12VAC5-371-360. Clinical records Cross Reference POC for F622 Cross reference to F622 12 VAC 5-371-250. Resident Assessment 12VAC5-371-250. Resident Assessment and Care and Care Planning Planning Cross Reference to F638 cross reference to F638 Cross Reference POC for F638 12VAC5-371-250. Resident Assessment and Care Planning 12 VAC 5-371-250. Resident Assessment cross reference to F641 and Care Planning Cross Reference to F641 12VAC5-371-140 Cross Reference to POC for F641 Based on staff interview, facility document review, employee record review and the Code of Virginia 12VAC5-371-140E3, the facility staff failed to 12 VAC 5-371-140 E.3 implement policies and procedures for abuse and Corrective Action(s): neglect for three of 25 employees hired in the last Employee #9, OTR now has a sworn two years. disclosure statement completed. A facility Incident and Accident for has been OSM (other staff member) #9, OTR completed for this incident. (Occupational Therapist, Registered) had a hire date of 01/02/2016. There was no sworn Employee #10 (OTR) and #11 (COTA) have statement on file. both had a background check completed by the appropriate state agency. A facility OSM # 10, OTR had a hire date of 08/21/2017. Incident & Accident form has been There was no criminal background check on file. completed for this incident. OSM # 11, COTA (Certified Occupational Therapy Identification of Deficient Practices & Assistant) had a hire date of 12/19/2017. There Corrective Action(s): was no criminal background check on file. All other contract employees may have been potentially affected. The Therapy Company The findings include: Human Resources department will audit 100% of all active contract therapy A review of 25 employees hired in the last two employee records to identify employees at years was conducted and revealed the following: risk. Any/all negative findings will be corrected at the time of discovery. A Facility Incident and Accident Report will OSM (other staff member) #9, OTR be completed for any/all negative findings. (Occupational Therapist, Registered) had a hire

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date of 01/02/2016. There was no sworn

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FORM APPROVED State of Virginia (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 495261 04/19/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 122 MORVEN PARK ROAD NW HERITAGE HALL NRSG AND REHAB LEESBURG, VA 20176 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) F 001 | Continued From Page 2 F 001 Systemic Change(s): statement on file. The facility policy and procedure has been reviewed and no changes are warranted at this time. The Contract Therapy Program OSM # 10, OTR had a hire date of 08/21/2017. manager was inserviced and issued a copy There was no criminal background check on file. of the policy & procedure regarding abuse prevention and pre-employment procedures OSM # 11, COTA (Certified Occupational Therapy) by the Administrator. Perspective employees Assistant) had a hire date of 12/19/2017. There will not be allowed to work until all required was no criminal background check on file. documentation has been obtained and verified by the Contract Therapy Program manager. On 04/19/18 at 11:00 a.m., an interview was conducted with OSM # 12, director of (Name of Monitoring: Rehabilitation Company's) rehabilitation The Administrator is responsible for department regarding the above information. maintaining compliance. The Administrator OSM # 12 stated, "We are unable to locate the and/or Human Resources Director will sworn statement for (OSM # 9). The background conduct monthly audits of all new hire checks were not done for (OSM # 10 and # 11) in contract therapy employee files each month the correct time frame." to maintain compliance. The administrator will review all audits and report aggregate OSM # 4, human resources director was findings to the Quality Assurance interviewed on 04/19/18 at approximately 11:15 Committee for review, analysis, and a.m. regarding the above information. When recommendations for changes in policy, asked who reviews the employee files for the procedure, and/or facility practice. (Name of Rehabilitation Company) OSM # 4 Completion Date: May 30, 2018 stated, "We're (Name of facility) is not responsible for making sure the paperwork for the contract employees is correct. It's the contract company's responsibility to ensure the employee's paperwork is accurate." On 04/19/18 at 12:00 p.m., an interview was conducted with ASM (administrative staff member) #1, administrator regarding the above information. ASM # 1 stated, "Last night (OSM # 4) and I checked the employee files of the rehabilitation department who are contracted." When asked if the contract employee files were check by the facility to ensure they were accurate

prior to last evening ASM # 1 stated, "No. We're

responsible to do so."

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State of Virginia

Cross of Virginia	Y	-	<del></del>				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	495261		B. WING		m 4. Addition of the contract	04/	/19/2018
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	ESS, CITY,	STAT	FE, ZIP CODE			
HERITAGE HALL NRSG AND F	REHAB	122 MORVE LEESBURG			AD NW		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	FULL	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
F 001 Continued From Pa	age 3	F	001				

A review of the facility's policy titled "Abuse, Neglect and Exploitation Prevention and reporting" documented, "The facility must: 3d. Background, reference and credentials's checks should be conducted on employees prior to or at the time of employment, by facility administration, in accordance with applicable state and federal regulations."

On 04/19/18 at 12:00 p.m. ASM (administrative staff member) # 1, the administrator, and ASM # 2, the director of nursing, were made aware of the above concerns.

No further information was provided prior to exit.

