PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

				OMB NO. 0938-03			
T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 -	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED			
	495261	B. WING		C 03/17/2017			
PROVIDER OR SUPPLIER		T	STREET AODRESS, CITY, STATE, ZIP C				
OF 11411 NEGO 4ND	051140		122 MORVEN PARK ROAD NW				
GE HALL NRSG AND	REHAB						
SUMMARYSTA	TEMENT OF DEFICIENCIES						
(EACH DEFICIENC)	MUST BE PRECEDEO BY FULL		(EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A DEFICIENCY)	SHOULD BE COMPLETIO			
INITIAL COMMENT	rs .	F 0	00				
survey was conducted Corrections are requered CFR Part 483 Federequirements. The survey/report will for the census in this factorial that the time of the consisted of 21 currous (Residents #1 throus record reviews (Residents #1 through #1 throug	ted 3/15/17 through 3/17/17. uired for compliance with 42 ral Long Term Care Life Safety Code llow. 164 certified bed facility was be survey. The survey sample ent resident reviews gh #21) and five closed bidents #22 through #26).		F248 Corrective Action(s): Resident #1 has been r activities. Resident #1 updated to reflect her a interests with appropri meet her needs.	eassessed for 's plan of care was activity needs and			
		F 24	18				
INTERESTS/NEED	S OF EACH RES						
(c) Activities.			All other residents wit severe cognitive impai	Corrective Action(s): All other residents with dementia and/or severe cognitive impairment may have been potentially affected. The facility			
comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			conducted a 100% rev with dementia and/or s impairment to identify Residents identified at care plans reviewed to resident's care plan ha meet the resident's inc psychosocial needs an changes or additional added to their resident	iew of all residents severely cognitive residents at risk. risk will have their determine if the s activities listed to lividual d interests. Any findings will be			
by: Based on observation document review, and was determined that provide individualized comprehensive asserts in the survey.	on, staff interview, facility and clinical record review, it the facility staff failed to discription according to the assment for one of 26 by sample, Resident #1.		Systemic Change(s): The current facility po has been reviewed and warranted at this time. Activities Director and will review the Long regulation manual for and to develop activity resident specific needs	I no changes are The current I Activity Assistants Form Care providing activities y programs to meet			
	PROVIDER OR SUPPLIER GE HALL NRSG AND SUMMARY STA (EACH DEFICIENCY REGULATORY OR L INITIAL COMMENT An unannounced M survey was conduct Corrections are req CFR Part 483 Fede requirements. The survey/report will fo The census in this 1 144 at the time of the consisted of 21 curr (Residents #1 throu record reviews (Res 483.24(c)(1) ACTIV INTERESTS/NEED: (c) Activities. (1) The facility must comprehensive asset the preferences of e program to support a activities, both facilit individual activities a designed to meet the physical, mental, and each resident, encou and interaction in the This REQUIREMEN by: Based on observation document review, an was determined that provide individualized comprehensive asser residents in the surve	PROVIDER OR SUPPLIER GE HALL NRSG AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/15/17 through 3/17/17. 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 144 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and five closed record reviews (Residents #22 through #26). 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging-both independence and interaction in the community. This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER GE HALL NRSG AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/15/17 through 3/17/17. 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 144 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and five closed record reviews (Residents #22 through #26). 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide individualized activities according to the comprehensive assessment for one of 26 residents in the survey sample, Resident #1.	PROVIDER OR SUPPLIER GE HALL NRSG AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/15/17 through 3/17/17. 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 144 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #22 through #26). 483.24(c)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES (c) Activities. (d) Activities. (d) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide individualized activities as control and the comprehensive assessment for one of 26 residents in the survey sample, Resident #1.			

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

3/28/17

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 projection 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.

RECEIVED

511 Facility ID: VA0115

If continuation sheet Page 1 of 70

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

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-03					
STATEMENT	T OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
		495261	B. WING		····	C 03/17/2017		
NAME OF I	PROVIDER OR SUPPLIER) <u></u>		STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
HERITAC	GE HALL NRSG AND I	REHAB			MORVEN PARK ROAD NW 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 CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LO BE COMPLETION		
F 248	Continued From pa	age 1	F 2	248				
	•	ssed preferences on 3/15/17						
	The findings include				Monitoring: The Activities Director is resp maintaining compliance. Wee			
	4/15/16 with diagnoto: Alzheimer's disepulmonary disease and depression. Or (minimum data set) an assessment reference and long term mem moderately impaired She was coded as massistance of two stand as being dependence of the company of the compa				activity coding on Compreher assessments and activity care be conducted by the Activity I and/or RCC coinciding with the calendar to monitor for complements of findings will be reported in the committee Aggregate findings will be reported in the committee Aggregate findings will be reported in the committee for review, and recommendations of change in policy, procedure, or practice. Completion date: 4/28/2017	nsive MDS plans will Director the MDS iance. All rted to the for review. ported to the alysis, and a facility		
	Resident #1 during - 3/15/17 at 11:30 a reclined in her chair intermittently. No foat this time 3/15/17 at 2:00 p.r in her chair in her rotelevision, which wa room. The resident The television did no - 3/15/17 at 5:10 p.r. her back in bed, with were reaching/grass	rvations were made of the survey: a.m The resident was r in the day room, yelling ormal activity was taking place m The resident was reclined oom. The chair faced the as in the far corner of the t's back was to the hallway. The resident was lying on the her eyes open. Her arms ping in the air. There was no sic playing in the room.						

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

- 3/16/17 at 7:45 a.m. - The resident was reclined

in her chair, and a CNA (certified nursing assistant) was pushing the chair into the day

Even1 ID: 422511

Facility ID: VA0115

If continuation sheet Page 2 of 70



PRINTED: 03/22/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			(M APPROVED D. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	ATE SURVEY OMPLETED				
		495261	B. WING			0:	C 3/17/2017
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HALL NRSG AND	REMAR		1	22 MORVEN PARK ROAD NW		
HEININ	JE TIALL MOGAMD	NERAB		L.	EESBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 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)	DBE	IX5I COMPLETION DATE
F 248	- 3/16/17 at 9:10 a.r in her chair in her chair in her roclosed. The chair frint the far corner of twas to the hallway. sound coming from - 3/16/17 at 10:15 a reclined in her chair were closed. The cwhich was in the far resident's back was did not have sound dayroom, a word gathe unit's dining room shown on the televis - 3/16/17 at 10:45 a. reclined in her chair were open. The chawas in the far corner back was to the hall have sound coming dayroom, the televis	was yelling intermittently. m The resident was reclined from, and her eyes were acced the television, which was the room. The resident's back. The television did not have itm The resident was in her room, and her eyes hair faced the television, corner of the room. The to the hallway. The television coming from it. In the unit's me activity was occurring. In m, a movie musical was being sion. m The resident was in her room, and her eyes air faced the television, which r of the room. The resident's way. The television did not	F 2	!48			
	- 3/16/17 at 11:35 a. resident to the day re-3/16/17 at 1:10 p.m her back in her bed, There was no music - 3/16/17 at 4:30 p.m her back in bed. He	hown on the television. m A CNA transported the com in preparation for lunch. n The resident was lying on and her eyes were closed. playing in the room. n The resident was lying on reyes were open and her grasping in the air. There g in the room.					
		#1's admission MDS assessment reference date					

of 4/22/16 revealed the following activities as being very important to the resident: being



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ŀ		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING			C 03/17/2017
	PROVIDER DR SUPPLIER BE HALL NRSG AND I	REHAB		122	REET 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		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 248	news, and listening A review of the facili "Activities Assessm revealed, in part, th considerations: Mo takes her glasses of themResident aw afternoon, evening. day/activity roomC - adapted to resider watching TVHobb during lifetime: Enjeplant, news, weathe program, Loves cat be outdoors, used t Spending time with A review of the clinic revealed the followin written by OSM (oth activities assistant: adequate, no use of impaired, no use of resident continues t Resident sometime: rarely makes self-ur alert/oriented to her her care and visits of fher time in her ro and rest. The activi sensory and recreat present level of fund	ity document entitled ent 3.0" dated 3/13/17 e following: "Sight derately impaired, resident ff, doesn't want to wear ake all or most of the time: Preferred Activity Settings: General Activity Preferences - nt's current abilities: music, ies and leisure activities bys Mozart music, TV-animal er and The Voice music and dogs, Liked to walk and boski when younger. family." cal record for Resident #1 ng note dated 12/14/16, her staff member) #4, the "[Resident #1]'s hearing is f devices. Vision is highly glasses. Speech is clear and to yell out and is disruptive. In sunderstands others and highest and self. Daughter is involved in often. Resident spends most om where she can watch TV try staff will offer social, itional visits to maintain ctioning. Resident relies on ADL (activities of daily living)	F2	248		

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

A review of the comprehensive care plan for Resident #1 dated 4/15/16 and updated on

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 4 of 70



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-039	-	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495261	B. WING			C 03/17/2017		
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 03/11/2011	-	
HERITAG	GE HALL NRSG AND I	REHAB			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 PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
	has increased agita combativeness with and participate in gratimesEncourage a target - Pet therapy, outdoors on patio as through visits from f PROVIDE MUSIC FROOM (facility's cap where she can't be a the activity while allogroups." A review of the active for January, Februari in part, the following - January 2017: On during the whole modified the word indicated From the pet therapy, and "Music Hour." The realendar indicated From 1/30/17 (no time) - February 2017 - Ni during the month (all for 2/28/17, which womenth included eightherapy, and at least Hour." The notes or indicated Resident #group) on 2/1/17 (no 1:1 visit on 2/6/17, R	in part, the following: "Resident tion and verbal lack of attention to attend roup activities at and assist to group activities, music groups, going is tolerated. Offer socialization family, friends, and volunteers. FOR RESIDENT IN HER contains of the participate in the particip	F 2	48				

turned on 2/28/17.

#1 was visited in her room and the radio was

PR)NTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUI A. BUILO		PLE CONSTRUCTION		DATE SURVEY COMPLETEO
		495261	B. WING	·			C 03/17/2017
NAME OF F	PROVIOER OR SUPPLIER				STREET AOORESS, CITY, STATE, ZIP COOE		
HERITAG	E HALL NRSG AND I	REHAB		1	122 MORVEN PARK ROAD NW LEESBURG, VA 20176		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LO BE	IX5I COMPLETION OATE
F 248	Continued From pa	ge 5	F	248	В		
		activity indicated between					
		(1:1 visit on 3/9/17). The					
		ded four opportunities for pet st two activities called "Music					
		n the back of the calendar					
	indicated Resident	#1 was "yelling out" in her					
	room with the televi 3/6/17.	sion on at some point on					
	member) #4 was in was the primary act Resident #1's unit in how resident activity she stated each residendar for each mighlights activities offered and decline, stated: "If a resider 'declined' on the cal	is a.m., OSM (other staff terviewed. She stated she civities staff member on the mornings. When asked y participation is documented, sident has an individual activity month. The facility staff that residents are either, or participate in. OSM #4 at declines an activity, we write lendar." OSM #4 was asked eyor with a copy of Resident					
	#1's activity records						
	surveyor and provid records for Residen	p.m., OSM #4 returned to the led the requested activity to the stated when standard to the facility, she					

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

enjoyed socializing and group activities. She stated Resident #1 has declined in recent months, and now is more aggressive with her behaviors, and frequently yells out. OSM #4 stated: "We bring her into the group. Then if she is yelling and grabbing, we set her outside the group so she can still hear what is going on, but not be disruptive to others. If she keeps on yelling, we take her to her room and let her listen to TV or to music." She stated Resident #1 could not see the TV very well, but could hear it. She stated the resident had a CD player in her room

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 6 of 70



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES				MR NO	<u>. 0938-0391</u>		
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1, .	AULTIPLE CONSTRUCTION ILOING			(X3) OATE SURVEY COMPLETEO		
		495261	B. WING	i	.,,	1	C / 17/2017		
NAME OF F	PROVIOER OR SUPPLIER			ST	TREET AOORESS, CITY, STATE, ZIP COOE				
				12	22 MORVEN PARK ROAD NW				
HERITAG	SE HALL NRSG AND	REHAB		LI	EESBURG, VA 20176				
(X4) IO PREFIX TAG	(EACH OEFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	BE	(X5] COMPLETION OATE		
F 248	Continued From pa	=	F 2	248	 				
	referenced observa	was informed of the above ations of Resident #1 over the							
	morning, she was o	or. OSM #4 stated: "This out in the dining room for			:				
	CNAs offered to tal	came agitated. One of the ke her to her room." When							
	later to be a part of	f1 was offered the opportunity the group or to listen to the							
	musical playing in t	the day room, OSM #4 stated: y that." She stated she was							
	not aware that the r	resident's television did not ming from it or any music							
	playing. OSM #4 st	tated: "I will always turn her							
	at any time, OSM #	asked if she documented this 44 stated: "I don't always.							
	is responsible for as	stated the whole activities staff ssessing the resident and							
		dent's care plan. She stated aff is responsible for making							
	sure the care plan is	is followed. When shown ity care plan, OSM #4 was							
	asked if Resident #	4's care plan was being stated: "No. I can't say that it							
	is." When asked if	Resident #1 was receiving on-centered activities							
	according to her de	mentia, behaviors, and							
	how to do that. I an	1 #4 stated: "No. I'm not sure m just one person."							
		p.m., OSM #5, the activities							
	surveyor with currer	iewed. She provided the nt qualifications that meet the							
		er position. She stated that staff performs assessments							
		ey are "looking for what the at gives them joy." She stated							
	the team turns the a	assessments, which are							
	musiiv ducamienied	, OH BIE MINS, HIBU SUBLIM,							

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

interventions on the care plan. When asked who

EvenI IO: 422511

Facility IO: VA0115

If continuation sheet Page 7 of 70

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES ON					DMB NO. 0938-0391			
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495261	B. WING			05	C 3/ 17/2017	
	PROVIOER OR SUPPLIER BE HALL NRSG AND	REHAB		122 M	ET AODRESS, CITY, STATE, ZIP CODE IORVEN PARK ROAD NW BBURG, VA 20176	_1 00	9/17/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
	OSM #5 stated: "Tasked how activities person-centered pladementia who cannum #5 stated: "Well, I know she likes mussomeone there with could be doing a be program." On 3/16/17 at 5:10 pstaff member) #1, the director of nursing, a consultant, were infered. "Activity programs of each resident are avactivity programs are maximum individual to the individual residents." No further information (1)"COPD, or chronical disease, is a progress hard to breathe. "Progets worse over time from the website	pe 7 Inplementing the care plan, he activities team." When a fit into an individualized, an of care for a resident with ot verbalize her needs, OSM know she has dementia. I ic, and she likes presence her. Yes, it looks like we tter job of implementing her oum., ASM (administrative he administrator, ASM #2, the and ASM #4, the regional ormed of these concerns. It policy entitled "Activity, in part, the following: esigned to meet the needs of railable on a daily basis. Our designed to encourage participation and are geared dent's needsIndividualized are provided thatreflect the interests, hobbies, life resonal preferences of the on was provided prior to exit. In the constructive pulmonary asive disease that makes it agressive" means the disease of the gov/health/health-topics/topic	F 2-	18				

FORM CMS-2567(D2-99) Previous Versions Obsolete

(2) "Bipolar disorder, also known as

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 8 of 70

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	- & MEDICAID SERVICES			OMB NO. 0938-0391
	TOF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING		C 03/17/2017
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>	1	STREET ADDRESS, CITY, STATE, ZIF	
				122 MORVEN PARK ROAD NW	0002
HERITAC	GE HALL NRSG AND I	REHAB		LEESBURG, VA 20176	•
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE OATE
F 248	Continued From pa	ane 8	F 2	γ Λ Ω	
1 240	manic-depressive il causes unusual shi levels, and the abili tasks." This inform	Ilness, is a brain disorder that ifts in mood, energy, activity ty to carry out day-to-day lation is taken from the website ih.gov/health/topics/bipolar-dis		.48	
F 281 SS=D	483.21(b)(3)(i) SER PROFESSIONAL S	RVICES PROVIDED MEET STANDARDS	F 2	81	
	(b)(3) Comprehensi	ive Care Plans			
	as outlined by the comust-	ded or arranged by the facility, comprehensive care plan,		attending physician	nd #19 have had their a's notified that the
	This REQUIREMEN by: Based on staff inter	al standards of quality. NT is not met as evidenced rview, facility document review review, it was determined that		pace maker checks physician at time of #2, #11 and #19's F orders have been re	f admission. Resident Pace maker check eviewed and clarified.
	for three of 24 resid	o follow professional standards lents in the survey sample, dent #19 and Resident #2.		A Facility Incident completed for these	& Accident Form was incidents.
				Identification of D Practices/Correcti	
	with the physician, r Resident #11 at the			All other residents have been potential ADON and/or design	with pace makers may lly affected. The DON, gnee will conduct a residents with a pace
	-	ailed to clarify orders with the g a pacemaker for Resident dmission.			ny residents at risk. All at risk will be f discovery and the
		failed to clarify orders with the g a pacemaker for Resident #2 sion.			ker check orders. An nt form will be
	The findings include	<u>,</u> ,			

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

Event ID; 422511

Facility IO; VA0115

If continuation sheet Page 9 of 70

PRINTED: 03/22/2017

DEPARI	INCH OF HEALTH	AND HOWAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOIN	IPLE CONSTRUCTION 4G	(X3) OATE SURVEY COMPLETEO
		495261	B. WING_		C 0 3/1 7/ 201 7
NAME OF I	PROVIOER OR SUPPLIER	1	· · · · · · · · · · · · · · · · · · ·	STREET AOORESS, CITY, STATE, ZIP COO	
				122 MORVEN PARK ROAD NW	
HERITAG	SE HALL NRSG AND	REHAB		LEESBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	JO PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCEO TO THE APP OEFICIENCY)	OULO BE COMPLETION
F 281	Continued From pa	ne Q	F 28	81	
, 20,			1 20	' 1	
	1. Resident #11 was admitted to the facility on 1/31/13 with diagnoses that included but were not				
		er, diabetes, depression,			
	arthritis and demen				
	artifics and demen	ua.		Systemic Change(s):	
	The most recent MI	DS (minimum data set), a		The facility policy and pr	roondung has
		ent, with an ARD (assessment		been reviewed and no rev	vicione are
		2/8/17 coded the resident as		warranted at this time. The	ie niirsino
		ng term memory problems		assessment process as ev	idenced by the
		impaired for daily decision		24 Hours Report, docume	entation in the
	making. The reside	nt was coded as requiring		medical record and physic	cian orders
	assistance for all ac	tivities of daily living.		remains the source docum	nent for the
				development and monitor	ing of care
		ent's care plan initiated on		which includes, obtaining	, clarifying,
		d, "Problem/Need INABILITY		transcribing and administ	ering physician
		S (activities of daily living)		ordered medications and t physician order. Licensed	reatments per
		SECONDARY TO HTN		inserviced by the DON an	Start Will be
		EMAKERApproaches		nurse consultant on the po	wor regional
) PER ORDER, MONITOR		procedure for following p	nicy & hysician ordered
	VITAL SIGNS."			medication and treatment	orders.
	Review of the physi-	cian order sheet (POS) dated			
	and signed 3/13/17			Monitoring:	
		arding what and or if any		The DON is responsible for	or maintaining
	monitoring of Resid-	ent #11's pacemaker function		compliance. The DON and review all new resident ad	1/or ADON will
	should be complete	d.		weekly to ensure any resident	illission orders
				with a Pace maker has the	
		h 2017 MAR (medication		pace maker check orders v	wppropriate Vriffen and
	administration recor			clarified. Any negative fin	dings will be
		rding what and or if any		corrected and clarified at t	he time of
		e done of Resident #11's		discovery. The results of the	hese audits will
	pacemaker function			be reported to the Quality.	Assurance
	_ , _ ,			Committee for review, and	dysis, &
		al record did not evidence a		recommendations for chan	ge in facility
	cardiology consult. F	Further review of the record		policy, procedure, and/or p	ractice.

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

the resident was admitted.

did not evidence documentation that the

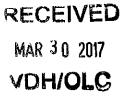
pacemaker's functioning had been checked since

Event IO: 422511

Facility IO: VA0115

Completion Date: 4/28/2017

If continuation sheet Page 10 of 70



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	D. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1] PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) OA	TE SURVEY MPLETEO
		495261	B. WING		n:	C 3/ 17/201 7
	PROVIOER OR SUPPLIER BE HALL NRSG AND	REHAB		STREET AOORESS, CITY, STATE, ZIF 122 MORVEN PARK ROAD NW LEESBURG, VA 20176		<i>3/11/2</i> 0
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES ' MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		ON SHOULO BE HE APPROPRIATE	(X5) COMPLETION OATE
F 281	p.m. with RN (regis coordinator. When care plan for Reside had. RN #1 was asl care for a pacemak any signs and sympshould call the doct symptoms they should cla asked who should of #1 stated, "Nursing. would clarify it." An interview was cop.m. with LPN (licer nurse caring for Resa resident with a pa #4 stated, "It needs depending on the cathree months or ever she had any resider stated, she did not. #11 had a pacemak On 3/16/17 at 5:15 pmember) #1, the addirector of nursing, with gindings. When asked staff used, ASM #2 An interview was co 3/17/17 at 9:15 a.m. symptoms staff look pacemaker. LPN #6 (fainting) and bradyow When asked what we was a staff used, what we was every was a symptoms staff look pacemaker. LPN #6 (fainting) and bradyow when asked what we was a symptom asked what we was a staff used, and bradyow was a symptom asked what we was a symptom	anducted on 3/16/17 at 12:40 tered nurse) #1, the MDS asked who had created the ent #11, RN #1 stated she exted how staff knew how to er. RN #1 stated, "If there are stoms that are adverse they or." When asked what uld observe for, RN #1 stated, rify it with the doctor. When starify the pacemaker care, RN If I saw something missing I should be every expected and the state of the	F 2	.81		

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

doctor."

Even(IO: 422511

Facility IO: VA0115

If continuation sheet Page 11 of 70

PRINTED: 03/22/2017 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OM	<u>B NO. 0938-0391</u>		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495261	B. WING			C 03/17/2017		
NAME OF F	PROVIDER OR SUPPLIER		<u>' </u>	STREET ADDRESS, CITY, ST	TATE, ZIP CDDE			
LICOLTAC	SE HALL NECC AND I	DELLAR	[122 MORVEN PARK ROAL	D NW			
HERHAU	BE HALL NRSG AND I	KENAD		LEESBURG, VA 20176	i			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT) CROSS-REFERENCE	AN OF CORRECTION IVE ACTION SHOULD B ED TO THE APPROPRIA FICIENCY)			
F 281	Continued From pa	ge 11	F 2	81				
	a.m. with ASM #3, t #3 was asked about a resident was adminimate a saked about a resident was adminimate a saked about on demand pacemate a saked about what the medically stable or check them. If they we need to check it when asked how some a sepanded on their purity with a saked and their purity with a saked and the saked a saked and the saked and the saked a sak	conducted on 3/17/17 at 9:48 the resident's physician. ASM to the process he follows when litted to the facility with a stated, "Most residents are akers (1) and I talk with the they want to do.) If they're asymptomatic don't need to a depend on the pacemaker every three to six months." taff knew which residents bacemaker, ASM #3 stated, orders. I expect them to call they expect me to write the start a new process; it'll be on tell them what to do (with the						
	Care of a Resident following document sure the resident has	ity policy titled "Pacemaker, with a" revealed, in part, the ation; "Monitoring. 5. Make as a medical identification card						
	that indicates he or she has a pacemaker. The medical record must contain this information as well. Documentation. 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a) The name, address and telephone number of the cardiologist; b. Type of							
		e of leads; d. Manufacturer al number; f. Date of implant;						
	Practice, 10th editio	cott Manual of Nursing n, page 356, "Follow-up 1. patient has a copy of ECG						

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

(electrocardiogram) tracing (according to facility policy) for future comparisons. Encourage patient

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 12 of 70

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

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CEIVIE	CO T OTT MEDICATIVE	3,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	[T	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i		CONSTRUCTION	(X3) DATE SI COMPLE	
,			A. BUILL			С	
		495261	B. WING		······································	03/17/	2017
NAME OF F	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL NRSG AND I	REHAB			MORVEN PARK ROAD NW		
HERRIAG	T HALL HIGO AND I	· · · · · · · · · · · · · · · · · · ·		LEE	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	tX5) OMPLETION OATE
₽ 281	Continued From pa	rae 12	⊑ '	281			
1 201		emaker checkups for	1 4	_0 ,			
	monitoring function	and integrity of pacemaker"					
İ	_						
	(1) Demand pacem	aker A demand pacemaker trhythm. It only sends]
		your heart if your heart is					
	beating too slow or	if it misses a beat. This					
	information was obt						
	nttps://www.nntbl.ni cs/pace/howdoes	h.gov/health/health-topics/topi					
	C3/pacc/flowdoc3						
		as Clinicians have long					
		entially serious manifestations rdia. However, even marked					
		en be physiologic, and in the					
	presence of impaire	ed ventricular function may					
		pensatory hemodynamic					
	bradycardia include	of the sinoatrial node producing a failure of impulse formation,					
	sinoatrial conductio						
	sinus-perinodal ree	ntry, carotid sinus					
		I the constellation of brady- as that compose the "sick					
		his information was obtained					
	from:						
	https://www.ncbi.nlr	m.nih.gov/pubmed/6826942					
		s admitted to the facility on					
		oses that included but were					
	not limited to: pacer anxiety, anemia and	maker, high blood pressure,					
	anviery, anemia am	a maney arounded.					
		DS, a quarterly assessment,					
		3/17 coded the resident as					
	naving scored 5 out	t of 15 on the BIMS (brief I status) indicating that the					}
	resident was severe	ely impaired cognitively. The					
		as requiring assistance with				•	

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

all activities of daily living.

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 13 of 70

MAR 3 0 2017 VDH/OLC

PRINTED: 03/22/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C		. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DAT COM	E SURVEY MPLETED
		495261	B. WING	·		1	C /17/2017
	PROVIDER OR SUPPLIER GE HALL NRSG AND I	REHAB		12	REET ADDRESS, CITY, STATE, ZIP CODE 12 MORVEN PARK ROAD NW 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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	Continued From pa	ge 13	F2	281			
	12/12/14 document TO PERFORM ADL SECONDARY TO MEDS (medications VITAL SIGNS." Review of the physic dated 12/12/14 did regarding the pacen Review of the March sheet) did not evide the care and monito pacemaker. Review of the March documentation rega of the resident' pace Review of the clinical documentation of a repacemaker function An interview was coi p.m. with RN (registe coordinator. When a care plan for Reside had. When asked had a pacemaker, RN #1 signs and symptoms call the doctor." Whet they should observe should clarify it with it should clarify the pace	n 2017 POS (physician order nee documentation regarding ring of the resident's n 2017 MAR did not evidence rding the care and monitoring emaker. al record did not evidence cardiology consult or that the					

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

clarify it."

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 14 of 70

PRINTED: 03/22/2017

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED 0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		495261	B. WING			0	C 3/17/2017
	PROVIDER OR SUPPLIER GE HALL NRSG AND	REHAB		122	REET ADDRESS. CITY. STATE. ZIP COD MORVEN PARK ROAD NW ESBURG, VA 20176		0/11/2011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULO BE	(X5) COMPLETION DATE
	p.m. with LPN (licer nurse caring for Rea a resident with a pa #4 stated, "It needs depending on the cathree months or ever she had any resider stated, she did not. #19 had a pacemak On 3/16/17 at 5:15 pmember) #1, the addirector of nursing, with findings. When aske staff used, ASM #2 An interview was co 3/17/17 at 9:15 a.m. staff look for in a resident would do should LPN #5 stated, "Dizzines bradycardia (slow he staff would do should LPN #5 stated, "Called An interview was co a.m. with ASM #3, the #3 was asked about a resident was admit pacemaker. ASM # on demand pacema (about what they was table or asymptoma if they depend on the check it every three how staff knew which	onducted on 3/16/17 at 1:30 insed practical nurse) #4, the sident #19. When asked how idemaker was monitored, LPN to be checked periodically ardiologist. It could be every ery six months. When asked if ints with a pacemaker, LPN #4 When informed that Resident for LPN #4 did not respond. In Masked what symptoms at a what nursing standard the stated, "Lippincott." Inducted with LPN #5 on when asked what symptoms sident with a pacemaker, LPN s, syncope (fainting) and eart beat)." When asked what d these symptoms occur, I the doctor." Inducted on 3/17/17 at 9:48 in the process he follows when itted to the facility with a 3 stated, "Most residents are kers and I talk with the family int to do.) If they're medically atic don't need to check them. It is pacemaker we need to to six months." When asked the residents depended on the facility write it on the sidents depended on the facility write it on the facility	F2	:81			

symptoms but they expect me to write the order.

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			<u>O</u>	MB NO. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING	i		C 0 3/17/2017
NAME OF I	PROVIDER OR SUPPLIER		1	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
				12	22 MORVEN PARK ROAD NW	
HERITAG	SE HALL NRSG AND	REHAB		LI	EESBURG, VA 20176	
(X4) ^I D PREFIX TAG	(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 APPROP DEFICIENCY)	BE COMPLETION
F 281	Continued From pa	age 15	F	281		
	I'm going to start a	new process; it'll be on a ell them what to do (with the				
	No further informat	ion was provided prior to exit.				
	No further informat end of the survey p					
	4/18/16 with a read diagnoses that including high blood pressure	s admitted to the facility on mission on 8/12/16 with uded, but were not limited to, e, dementia, anxiety, osis, and a pacemaker.				
	set) was a quarterly (assessment reference Resident #2 was conterview of mental 10 out of a possible	recent MDS (minimum data y assessment with an ARD ence date) of 1/30/17. oded on the BIMS (brief status) as having a score of e 15, indicating that Resident oderately impaired with daily				
	in part, a comprehent that revealed the form in Problem Onset: 6 CARDIAC COMPL CAD (coronary arter (hypertension), AN with exertion), PACEMAKER CHEFOR IMPAIRED CADIFFICULTY BREA	GINA PECTORIS (chest pain EMAKER. Approaches: CKS PER ORDER, ASSESS				

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					0. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	I ' '		CONSTRUCTION		TE SURVEY MPLETEO
		495261	B. WING			03	C 9/1 7/20 17
NAME OF F	PROVIOER OR SUPPLIER		<u> </u>	STR	EET AOORESS, CITY, STATE, ZIP COOE		
HERITAG	E HALL NRSG AND I	REHAB		-	MORVEN PARK ROAD NW SBURG, VA 20176		
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULO BE	JXSI COMPLETION OATE
F 281	not reveal any phys or nursing notes the pacemaker. On 3/16/17 at 9:20 nurse) #1, a unit may information reg pacemaker checks On 3/16/17 at 12:50 conducted with RN MDS coordinator. Fresponsible for devestated that she was determined what we stated that she wou nursing notes, phys area assessment) to accordingly. RN #1 Resident #2's care preview the care planhad care planned for that she would have that Resident #2 haplanned for it. RN # "pacemaker checks stated that the nursi pacemaker check pdemonstrated signs failure. RN #1 was referring to in the ca "There was no order	esident #2's clinical record did ician notes, physician orders at addressed Resident #2's a.m. LPN (licensed practical anager, was asked to provide arding pacemaker orders and for Resident #2. b. p.m. an interview was (registered nurse) #1, the RN #1 was asked if she was eloping care plans, RN #1. RN #1 was asked how she build be care planned. RN #1 ld review the hospital records, ician notes and CAA (care riggers and care plan was asked specifically about blan and RN #1 was asked why she or a pacemaker. RN #1 stated a seen on the hospital records d a pacemaker and care the was asked to explain what per order meant. RN #1 ng staff should have a erformed if the resident and symptoms of pacemaker asked what "order" she was are plan. RN #1 stated, r, it is a generalized care plan	F	281	CEPICIENCY		
	was a floor nurse who mean to her. RN #1 nurse I would contact	taff." RN #1 was asked if she nat this statement would stated, "If I read this as a ct my physician and ask for he pacemaker." RN #1 was					

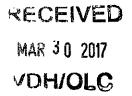
FORM CMS-2567(02-99) Previous Versions Obsolete

asked if she verified that there was an order

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 17 of 70



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			Ol	MB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONS	STRUCTION	(X3] OATE SURVEY COMPLETEO
		495261	B. WING			C 03/17/2017
NAME OF S	PROVICER OR SUPPLIER		1	STREET	AOORESS, CITY, STATE, ZIP COOE	·
				122 MO	RVEN PARK ROAD NW	
HERITAG	BE HALL NRSG AND	REHAB		LEESB	URG, VA 20176	
(X4) IO PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION]	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO PROSS-REFERENCED TO THE APPROPE OEFICIENCY)	BE COMPLETION
F 281	entry "pacemaker of stated, "This is star resident with a pace would (as the MDS nursing's attention is physician clarification asked whether or not staff that there was she did not. On 3/16/17 at approximate any further docume pacemaker. LPN #1 stated, "So The families may be check and have a sout to their cardiolo there were no dischard members what wood regarding the pacer to the physician." Lesident #2's pace (Resident #2) has a relationship. The sepacemaker equipm whether or not the pregarding pacemaker did not know. On 3/16/17 at approximation of the pregarding pacemaker did not know.	maker when she wrote the checks per order." RN #1 andard practice for managing a semaker. If there was no order I coordinator) bring this to so that they could obtain on and an order." RN #1 was ot she notified the nursing no order. RN #1 stated that eximately 3:00 p.m. an ucted with LPN #1, a unit stated that she did not have entation on Resident #2's 14 was asked whether or not lers provided for a pacemaker. The people don't get checked. Fing in their own equipment to echedule. Some residents go gists." LPN #1 was asked if harge orders and no family all the nursing staff do maker. LPN #1 stated, "It's up LPN #1 was asked about maker. LPN #1 stated, "She a son, they have a love/hate on did not bring any ent." LPN #1 was asked obysician was contacted er orders. LPN #1 stated she oximately 4:00 p.m. ASM	F 2	281		
	nursing, provided a a physician with no	f member) #2, the director of history and physical signed by date of signature and a summary dated 4/9/16. Both				

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

documents had a fax date stamp of 3/16/17.

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 18 of 70



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) OATE SURVEY COMPLETEO
	ļ	495261	B. WING		C 03/17/2017
NAME OF PI	ROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	
HERITAGI	E HALL NRSG AND F	REHAB		122 MORVEN PARK ROAD NW	
HERMAO	- TIMEL INCOVING			LEESBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG		JLO BE COMPLÉTION
	received and she coreceived them. ASI history and physical stated that she aske afternoon. The hist physician document "Pacer check as ne symptomatic like diz ASM #2 stated that been checked wher review of the discharegarding Resident revealed, in part, the "Cardiac pacemake syndrome (a cardiac There was no docur #2's pacemaker had asked whether or no obtained from the p Resident #2's pacer policy was requeste and care of a reside On 3/17/17 at 8:40 a conducted with RN was asked what she orders on admission pacemaker. RN #3 know the rate that the what to do if the pace asked whether or no order for managing that she should. RN have an order what she would call the p	when the documents were onfirmed that she had just M #2 was asked when the I had been written. ASM #2 ed the physician to write it that tory and physical signed by the ted, in part, the following; leded if pt (patient) is zziness or syncope (fainting)." Resident #2's pacemaker had a she was in the hospital. A arge summary provided #2's 4/9/16 admission e following documentation; or placement for sick sinus or dysrhythmia) July 2014." mentation that stated Resident do been checked. ASM #2 was not an order should have been chysician regarding care of maker, ASM #2 stated yes. A red regarding obtaining orders ent with a pacemaker. a.m. an interview was (registered nurse) #3. RN #3 e would do if she did not have a stated, "It is important to the pacemaker is set at, and be pacemaker is set at, and be she would have a physician the pacemaker. RN #3 was sot she would have a physician the pacemaker. RN #3 stated whysician and obtain an order.	F 2		
	On 3/17/17 at 9:55 a	a.m. an interview was			

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

conducted with ASM #3, the medical doctor.

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 19 of 70

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
		495261	B, WING		C 03/17/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•
	SELIALI NEGO ANDI	DELLAD	l	122 MORVEN PARK ROAD NW	
HERITAG	E HALL NRSG AND	RENAB		LEESBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE COMPLETION
F 281	resident was admitted existing pacemaker on the patient as to pacemaker, how of ASM #3 was asked to do. ASM #3 statindicate when it (the checked and that if cardiac symptoms to checked and an application of the physician to the orders." ASM #3 about Resident #2.	I what his process was when a ted to the facility with an r. ASM #3 stated, "It depends how we manage the ten it should be checked." I how nursing would know what ed, "I would write an order and e pacemaker) should be the resident was having then the pacemaker should be pointment made to #3 was asked what the nursing ere was no order in the clinical ated, "It is up to the nurse to an. The nursing staff depends write the order. It should be in #3 was asked specifically ASM #3 stated that there an order written by him	F2	'81	
F 282 \$\$=D	Care of a Resident following document sure the resident had that indicates he or medical record must well. Documentation a pacemaker, documedical record and card upon admission telephone number of pacemaker; c. Typiand model; e. Seriand g. paced rate.	lity policy titled "Pacemaker, with a" revealed, in part, the ation; "Monitoring. 5. Make as a medical identification card she has a pacemaker. The st contain this information as on. 1. For each resident with ment the following in the on a pacemaker identification on: a) The name, address and of the cardiologist; b. Type of e of leads; d. Manufacturer al number; f. Date of implant; RVICES BY QUALIFIED ARE PLAN	F 2	F282 Corrective Action(s): Resident #1's attending physis been notified that facility staff provide activities as outlined of #1's comprehensive care plantincident and accident form has completed for this incident.	failed to n Resident A facility

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

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 20 of 70



PRINTED: 03/22/2017 FORM APPROVED

	THE TOP MEDICAL DE	A MEDICALD CEDVICES				NO OCCO COL
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				DMB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MU A. BUILO		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
			ļ			С
		495261	B. WING	;		03/17/2017
NAME OF I	PROVIOER OR SUPPLIER			STR	REET AOORESS, CITY, STATE, ZIP COOE	
UEDITA	SELIAL / NECC AND	DELIAD		122	MORVEN PARK ROAD NW	
HERITAG	SE HALL NRSG AND	REHAD		LEF	ESBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	O BE COMPLETION
F 282	as outlined by the omust- (ii) Be provided by accordance with eacare. This REQUIREMED by: Based on observation document review, a was determined that follow the written places are in the sure. The facility failed to Resident #1's compa/15/17 and 3/16/13	ded or arranged by the facility, comprehensive care plan, comprehensive care plan, qualified persons in ach resident's written plan of NT is not met as evidenced tion, staff interview, facility and clinical record review, it at the facility staff failed to an of care for one of 26 vey sample, Resident #1.	F	282	Identification of Deficient Practices/Corrective Action All other residents may have potentially affected. The Acti and/or Activity Assistants wi 100% review of all resident a plans to identify residents at residents identified at risk wi corrected at time of discovery Incident & Accident form wi completed for each negative attending physician will be n each incident. Systemic Change(s): The facility policy and proce Activities has been reviewed revisions are warranted at th Activity Director will inserv activity staff and Nursing sta requirement to provide resid activities daily per the reside care plan.	been vity Director Il conduct a ctivity care risk. All Il be y and an Il be finding. The otified of dure for and no is time. The ice all ff on the ent specific
	4/15/16 with diagnote: Alzheimer's dispulmonary disease and depression. O (minimum data set) an assessment reference and long term mem moderately impaire She was coded as assistance of two sand as being deper	dmitted to the facility on oses including, but not limited ease, chronic obstructive (1), bipolar disorder, anxiety in the most recent MDS, a quarterly assessment with erence date of 12/20/16, oded as having both short term fory difficulties, and as being d for making daily decisions. The requiring the extensive taff members for bed mobility, and the unit. She was coded			Monitoring: The Activity Director is responding to maintaining compliance. The Director and/or Activity Assembly perform reviews of the residence of the coinciding with the Care plange monitor for compliance. An findings will be corrected at discovery and revisions will the care plange as needed. Again findings of these reviews with the Quality Assurance Concepts of the plange	e Activity , istant will ents Activity dars n schedule to y/all negative time of be made to gregate ll be reported emmittee is, and

as being highly visually impaired.

The following observations were made of

policy, procedure, and/or practice.

Completion Date: 4/28/2017

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

PR)NTED; 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	OF OFFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		LTIPLE CONSTRUCTĮON DING		ATE SURVEY OMPLETEO
			, a Built			С
		495261	B. WING		0	3/17/2017
	PROVIOER OR SUPPLIER SE HALL NRSG AND	REHAB		STREET AOORESS, CITY, STATE, ZIP COOI 122 MORVEN PARK ROAD NW LEESBURG, VA 20176	Ē	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		IOULO BE	(X5) COMPLETION OATE
F 282	reclined in her chaintermittently. No fat this time. - 3/15/17 at 2:00 p. in her chair in her relevision, which wroom. The resident The television did resident to the television did resident to the television of the television on or mustelevision on the far corner of was in the far corner of was in the far corner of was in the far corner of the corner of the far corner of the	the survey: a.m The resident was r in the day room, yelling ormal activity was taking place m The resident was reclined oom. The chair faced the as in the far corner of the t's back was to the hallway. not have sound coming from it. m The resident was lying on th her eyes open. Her arms sping in the air. There was no sic playing in the room. m The resident was reclined CNA (certified nursing hing the chair into the day was yelling intermittently. m The resident was reclined oom, and her eyes were faced the television, which was the room. The resident's back The television did not have it. a.m The resident was r in her room, and her eyes chair faced the television, or corner of the room. The so to the hallway. The television coming from it. In the unit's ame activity was occurring. In om, a movie musical was being	F	282		

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

have sound coming from it. In the unit's

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 22 of 70

MAR 3 0 2017
VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF OERICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER LOENTIFICATION NUMBER: 495261 NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND REHAB (X2) MUMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE OF THE PROVIDER OF	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	<u>)MB NO</u>). 0938-039 <u>1</u>
NAME OF PROVIOER OR SUPPLIER HERITAGE HALL NRSG AND REHAB (X4) ID PREFIX TAGS REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 22 dayroom, the television was tuned to a soothing music station. In the unit's dining room, a movie musical was being shown on the television. - 3/16/17 at 11:35 a.m A CNA transported the resident to the day room in preparation for lunch 3/16/17 at 1:10 p.m The resident was lying on her back in her bed, and her eyes were closed. There was no music playing in the room 3/16/17 at 4:30 p.m The resident was lying on her back in bed. Her eyes were open and her arms were reaching/grasping in the air. There was no music playing in the room. A review of Resident #1's admission MDS with an assessment reference date of 4/22/16 revealed the following activities as being very important to				1			COV	MPLETEO
NAME OF PROVIOER OR SUPPLIER HERITAGE HALL NRSG AND REHAB (X4) IO PREFIX (EACH OEFICIENCY MUST BE PRECEOSO BY FULL TAG) FREGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 22 dayroom, the television was tuned to a soothing music station. In the unit's dining room, a movie musical was being shown on the television. - 3/16/17 at 11:35 a.m A CNA transported the resident to the day room in preparation for lunch 3/16/17 at 11:30 p.m The resident was lying on her back in her bed, and her eyes were closed. There was no music playing in the room. - 3/16/17 at 4:30 p.m The resident was lying on her back in bed. Her eyes were open and her arms were reaching/grasping in the air. There was no music playing in the room. A review of Resident #1's admission MDS with an assessment reference date of 4/22/16 revealed the following activities as being very important to			495261	B. WING			1	
PREFIX TAG (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 22 dayroom, the television was tuned to a soothing music station. In the unit's dining room, a movie musical was being shown on the television. - 3/16/17 at 11:35 a.m A CNA transported the resident to the day room in preparation for lunch. - 3/16/17 at 1:10 p.m The resident was lying on her back in her bed, and her eyes were closed. There was no music playing in the room. - 3/16/17 at 4:30 p.m The resident was lying on her back in bed. Her eyes were open and her arms were reaching/grasping in the air. There was no music playing in the room. A review of Resident #1's admission MDS with an assessment reference date of 4/22/16 revealed the following activities as being very important to			REHAB		12	2 MORVEN PARK ROAD NW		
dayroom, the television was tuned to a soothing music station. In the unit's dining room, a movie musical was being shown on the television. - 3/16/17 at 11:35 a.m A CNA transported the resident to the day room in preparation for lunch. - 3/16/17 at 1:10 p.m The resident was lying on her back in her bed, and her eyes were closed. There was no music playing in the room. - 3/16/17 at 4:30 p.m The resident was lying on her back in bed. Her eyes were open and her arms were reaching/grasping in the air. There was no music playing in the room. A review of Resident #1's admission MDS with an assessment reference date of 4/22/16 revealed the following activities as being very important to	PREFIX	(EACH OEFICIENC)	Y MUST BE PRECEOEO BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPROF	O BE	COMPLETION
keeping up with the news, and listening to music. A review of the facility document entitled "Activities Assessment 3.0" dated 3/13/17 revealed, in part, the following: "Sight considerations: Moderately impaired, resident takes her glasses off, doesn't want to wear themResident awake all or most of the time: afternoon, eveningPreferred Activity Settings: day/activity roomGeneral Activity Preferences adapted to resident's current abilities: music, watching TVHobbies and leisure activities during lifetime: Enjoys Mozart music, TV-animal plant, news, weather and The Voice music program, Loves cats and dogs, Liked to walk and be outdoors, used to ski when younger. Spending time with family." A review of the clinical record for Resident #1 revealed the following note dated 12/14/16 and written by OSM (other staff member) #4, the	F 282	dayroom, the televish music station. In the musical was being - 3/16/17 at 11:35 a resident to the day - 3/16/17 at 1:10 p. her back in her bed. There was no musicular assessment referent to the following activities assessment referent the follow	sion was tuned to a soothing the unit's dining room, a movie shown on the television. I.m A CNA transported the room in preparation for lunch. I.m The resident was lying on I, and her eyes were closed. Ic playing in the room. I The resident was lying on er eyes were open and her glygrasping in the air. There and in the room. In #1's admission MDS with an ance date of 4/22/16 revealed it is as being very important to around animals such as pets, enews, and listening to music. It y document entitled the tangent of the time: In Preferred Activity Preferences of the time: In Preferred Activity Preferences on the current abilities: music, ones and leisure activities over Mozart music, TV-animal er and The Voice music is and dogs, Liked to walk and o ski when younger. I family." I cal record for Resident #1 and note dated 12/14/16 and	F:	282			

activities assistant: "[Resident #1]'s hearing is

PR)NTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	y		OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l .	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING		C 03/17/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS. CITY, STATE, ZIP CO	DE
HER)TA	GE HALL NRSG AND	REHAB		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		SHOULD BE COMPLETION
F 282	impaired, no use of resident continues Resident sometime rarely makes self unalert/oriented to her care and visits of her time in her cand rest. The actives sensory and recreating present level of funding sensory and recreating s	age 23 If devices. Vision is highly If glasses. Speech is clear and Ito yell out and is disruptive. Its understands others and Inderstood. Resident presents Itself. Daughter is involved in Itself. Daughter is involved in Itself. Resident spends most Itself will offer social, Itional visits to maintain Itioning. Resident relies on It ADL (activities of daily living)	F 2	282	
	A review of the com Resident #1 dated revealed, in part, th increased agitation with lack of attentio group activities at ti group activities, tar groups, going outdo Offer socialization to friends, and volunte RESIDENT IN HER capitalization). Sit	prehensive care plan for 4/15/16 and updated 3/13/17 e following: "Resident has and verbal combativeness in to attend and participate in mesEncourage and assist to get - Pet therapy, music pors on patio as tolerated. hrough visits from family, eers. PROVIDE MUSIC FOR R ROOM (facility's resident where she can't be			
	A review of the actifor January, Februain part, the following - January 2017: Orduring the whole m 1/16/17). The monfor pet therapy, and	nly one activity highlighted onth (Trivia at 10:00 a.m. on th included eight opportunities I at least four activities called notes on the back of the			

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

"passive/yelling out" on 1/16/17 (no time),

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 24 of 70

RECEIVED

MAR 3 0 2017

PRINTED: 03/22/2017 FORM APPROVED OMB NO 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391		
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		CONSTRUCTION		TE SURVEY	
		495261	B. WING	·		C 03/17/2017		
.,	ROVIDER OR SUPPLIER	REHAB		122	EET ADDRESS, CITY, STATE, ZIP CODE MORVEN PARK ROAD NW ESBURG, VA 20176			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION OATE	
F 282	"sleeping" on 1/19/on 1/30/17 (no time - February 2017 - N during the month (a for 2/28/17, which we month included eighterapy, and at least Hour." The notes of indicated Resident group) on 2/1/17 (n 1:1 visit on 2/7/17 but s #1 was visited in he turned on 2/28/17 March 2017 - One 3/1/17 and 3/15/17 month to date inclusted Resident." The notes of indicated Resident	om" on 1/18/17 (no time), 17 (no time) and "tv in room"		282				
	interviewed. She si activities staff mem the mornings. Whe participation is doct resident has an indieach month. The fathat residents are e participate in. OSM declines an activity, calendar." OSM #4	is a.m., OSM #4 was tated she was the primary ber on Resident #1's unit in a sked how resident activity amented, she stated each vidual activity calendar for acility staff highlights activities ither offered and decline, or I #4 stated: "If a resident we write 'declined' on the was asked to provide the y of Resident #1's activity						

On 3/16/17 at 12:50 p.m., RN (registered nurse)

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039			
	OF DEFICIENCIES OF CORRECTION	(X1) PRDVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETEO		
		495261	B. WING			1	C /1 7/20 17	
	PROVIDER OR SUPPLIER GE HALL NRSG AND I	REHAB		122	EET AODRESS, CITY, STATE, ZIP COOE MORVEN PARK ROAD NW ESBURG, VA 20176		117/2017	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	' MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	1X5) COMPLETION OATE	
F 282			F	282	DEFICIENCY)			
	playing. OSM #4 sta music on." When as at any time, OSM #4							

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

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES				MB NO	. 0938-0391	
STATEMENT	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY MPLETED
		495261	B. WING			1	C /17/2017
NAME OF F	PROVIOER OR SUPPLIER		1	STR	EET AODRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL NRSG AND	REHAB			MORVEN PARK ROAD NW ESBURG, VA 20176		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	developing the resithe whole facility strained the care plant in Resident #1's activities asked if Resident # followed, OSM #4's is." When asked if individualized, persaccording to her deassessments, she is to do that. I am just On 3/16/17 at 3:20 director, was intervaryor with currerequirements for he when the activities on the residents, the residents want, what the team turns the mostly documented interventions on the is responsible for in OSM #5 stated: "T asked how activitie person-centered pladementia who cannum #5 stated: "Well, I know she likes mussomeone there with could be doing a be program."	ssessing the resident and dent's care plan. She stated aff is responsible for making is followed. When shown ity care plan, OSM #4 was it's care plan was being stated: "No. I can't say that it Resident #1 was receiving on-centered activities mentia, behaviors, and stated: "No. I'm not sure how it one person." p.m., OSM #5, the activities itewed. She provided the int qualifications that meet the er position. She stated that staff performs assessments ey are "looking for what the at gives them joy." She stated assessments, which are if on the MDS, into specific exare plan. When asked who inplementing the care plan, the activities team. When is fit into an individualized, an of care for a resident with into verbalize her needs, OSM know she has dementia. I sic, and she likes presence—ther. Yes, it looks like we etter job of implementing her	F	282			
	staff member) #1, t	he administrator, ASM #2, the and ASM #4, the regional					

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

consultant, were informed of these concerns.

Event ID: 422511

Facility IO: VA0115

If continuation sheet Page 27 of 70

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OIVID IVO.	. 0330-0331
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		NSTRUCTION	СОМ	E SURVEY IPLETED
		495261	B, WING			1	C 17/2017
		433201	1		T ADORESS, CITY, STATE, ZIP CODE		1112011
NAME OF F	ROVIDER OR SUPPLIER				ORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND	REHAB		•	BURG, VA 20176		
(X41 ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	IX51 COMPLETION OATE
F 282	Care Plan" revealed care plan shall be resident's daily care to staff personnel to providing care or seridentComplet resident's chart and at the appropriate	lity policy entitled "Using the d, in part, the following: "The used in developing the e routines and will be available who have responsibility for ervices to the ed care plans are placed in the d/or in a 3-ring binder located nurses' eation must be consistent with	F2	282			
	No further information	tion was provided prior to exit.					
	disease, is a progr hard to breathe. "F gets worse over tin from the website	nic obstructive pulmonary essive disease that makes it rogressive" means the disease ne." This information is taken n.gov/health/health-topics/topic					
F 371 SS=E	causes unusual sh levels, and the abil tasks." This inform https://www.nimh.r order/index.shtml. 483.60(i)(1)-(3) FC STORE/PREPARE (i)(1) - Procure foo considered satisfar authorities.	illness, is a brain disorder that ifts in mood, energy, activity ity to carry out day-to-day nation is taken from the website hih.gov/health/topics/bipolar-dis		371	F 371 Corrective Action(s): The two unopened and exp of potato salad and coleslathe walk-in refrigerator durkitchen tour was immediate and disposed of. A facility Accident form was compleincident.	w identified initians the initians the initians the initial initians and initians a	in al

Facility ID: VA01t5

PRINTED: 03/22/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
STATEMENT	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495261	B. WING	i		C 03/17/2017
NAME OF P	ROVIOER OR SUPPLIER			S	STREET AOORESS, CITY, STATE, ZIP COOE	
				1	122 MORVEN PARK ROAD NW	
HERITAG	E HALL NRSG AND I	REHAB		L	LEESBURG, VA 20176	
(X4) IO PREFIX TAG	(FACH OFFICIENCY	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LOBE COMPLÉTION PRIATE DATE
					Identification of Deficient	Practices &
F 274	Cartinued From no	an 39	F	371	Corrective Action(s):	
F 371	Continued From pa		' '	<i>Ji</i> 1	ZHI OHIOI TOURGOING MAJ MA	
	and local laws or re	egulations.			potentially affected. The Forman Manager, and/or Registere	
	(9) Tri and take a	not prohibit or proyent			inspect the walk-in refriger	
	(II) I his provision of	oes not prohibit or prevent produce grown in facility			freezer to identify any neg	
	facilities from using	compliance with applicable			The walk-in freezers and re	
	gardens, subject to	ood-handling practices.			the kitchen will be monitor	
	Sale glowing and it	Jou-Hariding produces.			proper storage of food iten	
	(iii) This provision of	loes not preclude residents			food or unlabeled or undat	
	from consuming for	ods not procured by the facility.			identified in the kitchen fro	
					refrigerators or dry storage	
	(i)(2) - Store, prepa	re, distribute and serve food in			removed and disposed of a	
	accordance with pr	ofessional standards for food			discovery. A facility Incid Accident form will be con	
	service safety.				negative finding identified	
	(N/2) Horro o policy	regarding use and storage of			-	
	foods brought to re	sidents by family and other			Systemic Change(s):	, ,
	visitors to ensure s	afe and sanitary storage,			Current facility policy & p	
	handling, and cons	umption.			been reviewed and no char warranted at this time. Th	
	This REQUIREME	NT is not met as evidenced			Registered Dietician will i	
	bv:				Dietary Manager and dieta	
	Based on observa	tion, staff interview and facility			proper preparing, storing	
	document review it	was determined that facility			of food under sanitary con	
	staff failed to store	food in a safe and sanitary			as the policy and procedu	e for proper
	manner.				sanitation and hand washi	ng.
	The facility staff fail	led to discard expired potato			Monitoring:	
	salad and cole slav				The Dietary Manager is re	
					maintaining compliance.	
	The findings includ	e:			manager will complete the	
	_				storage audit tool daily to	
	An observation of t	he kitchen was made on			compliance. Any negative corrected at time of discor	
	3/14/17 at 11:40 a.i	m. with OSM (other staff			disciplinary action will be	
	member) #1, the fo	ood service manager. In the			warranted. The results of	these audits will
	walk in retrigerator	there was a seven pound			be reported to the Quality	
	unopened containe	er of potato salad with an 8/7/17 and a seven pound			Committee for review, an	
	expiration date of a	ed of cole slaw with an			recommendations for cha	nge in facility
	unopened containe	3/10/17. OSM #1 immediately			policy, procedure, and/or	practice.
		iners from the shelves and			Completion Date: 4/28/	2017

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

removed the containers from the shelves and

Event IO: 422511

Facility IO: VA0115

if continuation sheet Page 29 of 70

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

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

TO I OIL MIEDIONILE	. A MEDICAID SERVICES			ONB NO. 0938-0391
OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '		(X3) DATE SURVEY COMPLETEO
	495261	B. WING		C 03/17/2017
PROVIOER OR SUPPLIER		-	STREET AOORESS, CITY, STATE, ZIP COOE	
STUALL MOCO AND	DELLA D		122 MORVEN PARK ROAD NW	
JE HALL NKOG AND I	KEHAB		LEESBURG, VA 20176	
(EACH OEFICIENCY	Y MUST BE PRECEOEO BY FULL			OULO BE COMPLETION
disposed of them. V refrigerator for expire check it but I don't keep Review of the facility Guidelines For Confoods such as unbaan "expiration" or "uproduct should not be On 3/16/17 at 5:15 pmember) #1, the ad	When asked who checks the ired items, OSM #1 stated, "I know how it happened." by's policy titled, "Food Storage issumers" documented, "Other aked breads, are marked with use by date," which means the be consumed after that date." p.m. ASM (administrative staff dministrator, and ASM #2, the	F3	371	
483.30(a)(1)(2) RES SUPERVISED BY A §483.30(a) Physicia must ensure that— (1) The medical care supervised by a phy (2) Another physicia of residents when the unavailable. This REQUIREMEN by: Based on staff inter and clinical record re the facility staff failed supervision for three sample, Resident #1 Resident #2.	SIDENTS' CARE A PHYSICIAN an Supervision. The facility e of each resident is ysician; and an supervises the medical care neir attending physician is IT is not met as evidenced rview, facility document review eview, it was determined that d to provide physician e of 26 residents in the survey 11, Resident #19 and	F3	Corrective Action(s): The attending physicians ff #2, #11 and #15 have revie clarified the orders for Pacto be obtained. A facility In Accident forms has been on these incidents. Identification of Deficient Practices/Corrective Active All residents with Pace made affected affected. A fall residents with Pace made completed to identify residents with Pace made completed to identify residents will be contacted affected. All negative findings will time of discovery and their physician will be contacted revise the pace maker check Facility Incident & Accidence completed for each incident	ewed and e Maker checks ncident & ompleted for t on(s): kers may have 100% review of kers will be ents at risk. be corrected at attending I to review and k order. A nt form will be
	Continued From particles and its Required for nursing, windings. No further informatic 483.30(a)(1)(2) RESUPERVISED BY A \$483.30(a) Physicia must ensure that— (1) The medical care supervised by a phy (2) Another physicia of residents when the unavailable. This Required for three sample, Resident #1 Resident #2.	PROVIOER OR SUPPLIER SE HALL NRSG AND REHAB SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 29 disposed of them. When asked who checks the refrigerator for expired items, OSM #1 stated, "I check it but I don't know how it happened." Review of the facility's policy titled, "Food Storage Guidelines For Consumers" documented, "Other foods such as unbaked breads, are marked with an "expiration" or "use by date," which means the product should not be consumed after that date." On 3/16/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit. 483.30(a)(1)(2) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN §483.30(a) Physician Supervision. The facility must ensure that— (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide physician supervision for three of 26 residents in the survey sample, Resident #11, Resident #19 and	(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER: 495261 B. WING 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 29 disposed of them. When asked who checks the refrigerator for expired items, OSM #1 stated, "I check it but I don't know how it happened." Review of the facility's policy titled, "Food Storage Guidelines For Consumers" documented, "Other foods such as unbaked breads, are marked with an "expiration" or "use by date," which means the product should not be consumed after that date." On 3/16/17 at 5:15 p.m. ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of the findings. No further information was provided prior to exit. 483.30(a)(1)(2) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN §483.30(a) Physician Supervision. The facility must ensure that— (1) The medical care of each resident is supervised by a physician; and (2) Another physician supervises the medical care of residents when their attending physician is unavailable. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide physician supervision for three of 26 residents in the survey sample, Resident #11, Resident #19 and Resident #2.	A 95261 STREET ADORESS, CITY. STATE, ZIP CODE

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

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 30 of 70

RECEIVED

MAR 3 0 2017 VDH/OLC

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

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS	S FOR MEDICARE	E & MEDICAID SERVICES			OMP 14C). 0330-033
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION		TÉ SURVEY MPLETÉO
		495261	B. WING		C 03/17/2017	
NAME OF PROVIOER OR SUPPLIER HERITAGE HALL NRSG AND REHAB				COOE		
PREFIX (EACH DEFICIEN		ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION OATE
1						· - · · · · · · · · · · · · · · · · · ·

F 385 Continued From page 30

care of Resident #11's pacemaker at the time of admission.

- 2. The facility staff failed to provide orders for the care of Resident #19's pacemaker at the time of admission.
- 3. The physician failed to provide an order for the management of Resident #2's pacemaker at the time of admission.

The findings include:

1. Resident #11 was admitted to the facility on 1/31/13 with diagnoses that included but were not limited to: pacemaker, diabetes, depression, arthritis and dementia.

The most recent MDS (minimum data set), a quarterly assessment, with an ARD (assessment reference date) of 2/8/17 coded the resident as having short and long term memory problems and as moderately impaired for daily decision making. The resident was coded as requiring assistance for all activities of daily living.

Review of the resident's care plan initiated on 1/31/13 documented, "Problem/Need INABILITY TO PERFORM ADLS (activities of daily living) INDEPENDENTLY SECONDARY TO HTN (hypertension), PACEMAKER...Approaches MEDS (medications) PER ORDER, MONITOR VITAL SIGNS."

Review of the physician order sheet (POS) dated and signed 3/13/17 did not evidence documentation regarding what and or if any monitoring of Resident #11's pacemaker function should be completed. F 385

Systemic Change(s):

The Medical Director and attending Physicians have been inserviced by the administrator and/or DON on the current OLC regulations regarding physician services and coverage. Licensed staff will be inserviced by the administrator and/or DON on the communication and action to take if the physician is not timely with reviewing admission orders and/or needs to clarify resident specific orders and treatments upon admission per facility Policy & Procedure and physician standing orders.

Monitoring:

The DON is responsible for maintaining compliance. The DON and/or ADON will review all new resident admission orders weekly to ensure any residents admitted with a Pace maker has the appropriate pace maker check orders written and clarified. Any negative findings will be corrected and clarified at the time of discovery. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: 4/28/2017

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391		
STATEMENT	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			ONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
		495261	B. WING			C 03/17/2017	
NAME OF F	PROVIOER OR SUPPLIER		1	STRE	ET AOORESS, CITY, STATE, ZIP COOE		
			ł	122 [MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND I	KEHAB	ĺ	LEE	SBURG, VA 20176		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE COMPLÉTION	
F 385	Continued From pa	ge 31	F3	385			
	administration reco documentation rega monitoring of Resid should be complete Review of the clinic cardiology consult.	al record did not evidence a Further review of the record					
	did not evidence documentation that the pacemaker's functioning had been checked since the resident was admitted.						
	p.m. with RN (regis coordinator. When care plan for Residhad. When asked ha pacemaker, RN # signs and symptom call the doctor." When they should observe should clarify it with should clarify the page of the coordinate of the page of the coordinate of the coordinat	onducted on 3/16/17 at 12:40 tered nurse) #1, the MDS asked who had created the ent #11, RN #1 stated she now staff knew how to care for 1 stated, "If there are any is that are adverse they should nen asked what symptoms e for, RN #1 stated, that they is the doctor. When asked who accemaker care, RN #1 stated, omething missing I would					
	p.m. with LPN (licen nurse caring for Re a resident with a pa #4 stated, "It needs depending on the c three months or eve she had any reside stated, she did not.	onducted on 3/16/17 at 1:30 msed practical nurse) #4, the sident #11. When asked how accemaker was monitored, LPN to be checked periodically ardiologist. It could be every ery six months. When asked if ints with a pacemaker, LPN #4 When informed that Resident ker LPN #4 did not respond.					

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

On 3/16/17 at 5:15 p.m. ASM (administrative staff

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 32 of 70



PRINTED: 03/22/2017 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO	D. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION		ATE SURVEY OMPLETED
		49526 1	B. WING			0:	C 3/ 17/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL NRSG AND	REHAB		-	MORVEN PARK ROAD NW SBURG, 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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD 8E	(X5) COMPLETION DATE
F 385	director of nursing, findings. An interview was comount of the state	dministrator, and ASM #2, the were made aware of the onducted with LPN #5 on the whole with a pacemaker, LPN as, syncope (fainting) and leart beat)." When asked what all these symptoms occur,		85			
	"Monitoring 1. Monifailure by monitorin bradyarrhythmias (iwill be monitored re	with a" documented, iter the resident for pacemaker g the signs and symptoms of 2)3. The pacemaker battery emotely through the telephone ectionDocumentation 1. For					

Facility ID: VA0115

each resident with a pacemaker, document the following in the medical record and on a pacemaker identification are upon admission: a.

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				VAID IAC	. 0930-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	COM	E SURVEY MPLETED
		495261	B. WING				C / 17/2017
NAME OF F	ROVIDER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
				122	MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND	REHAB		LEE	SBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATIDN)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	IX5I COMPLETION DATE
F 385	Continued From pa	age 33	F:	385			
, 000	· ·	and telephone number of the	, ,	,,,,			
	cardiologist; b. Type	e of pacemaker; c. Type of urer and model; e. Serial					
	number; f. Date of	implant; and G. Paced rate."					
	No further information was obtained prior to exit.						
		of Nursing" 6th edition, 2005;					
		nd Anne Griffin Perry; Mosby,					
		e physician is responsible for eatment. Nurses are					
	obligated to follow	physician's orders unless they					
	believe the orders	are in error or would harm					
	clients."						
		naker A demand pacemaker					į
		t rhythm. It only sends your heart if your heart is					
		if it misses a beat. This					
	information was ob						
		ih.gov/health/health-topics/topi					
	cs/pace/howdoes						
		as Clinicians have long					
	of overame braduca	entially serious manifestations ardia. However, even marked					
		ten be physiologic, and in the					
	•	ed ventricular function may					
	offer important com	pensatory hemodynamic					
	effects. Disorders of	of the sinoatrial node producing					
	bradycardia include	e failure of impulse formation,					
	sinoatrial conduction sinus-perinodal ree	on block, concealed					
	hypersensitivity and	the constellation of brady-					
	and tachvarrhythmi	as that compose the "sick					
	sinus syndrome." T	his information was obtained					
	from:						
	https://www.ncbi.nli	m.nih.gov/pubmed/6826942					

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

EvenI ID: 422511

Facility ID: VA0115

If continuation sheet Page 34 of 70

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES				C	MB NO. 0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
		495261	B. WING			C 03/17/2017
NAME OF F	PROVIOER OR SUPPLIER		1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
TOTAL OF T	THO HOLL OF COLUMN			1	22 MORVEN PARK ROAD NW	
HERITAG	E HALL NRSG AND I	REHAB			EESBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF OEFICIENCY)	D BE COMPLETION
F 385	Continued From pa	ge 34	F 3	385		
	2. Resident #19 wa	s admitted to the facility on				
		noses that included but were				
		maker, high blood pressure,				
	anxiety, anemia and	d kidney diseases.				
	The most recent Mi	DS, a quarterly assessment,				
		3/17 coded the resident as				
		t of 15 on the BIMS (brief				
		I status) indicating that the				
		ely impaired cognitively. The				
	all activities of daily	l as requiring assistance with				
	all activities of daily	iivirig.				
	Review of Resident	#19's care plan dated				
		ed, "Problem/Need INABILITY				
		LS INDEPENDENTLY				
		PACEMAKERApproaches R, MONITOR VITAL SIGNS."				
	MEDO! ER ORDE!	i, month of think of the				
		ician's history and physical				
		not evidence documentation				
	regarding the pacer	maker.				
	Review of the Marc	h 2017 physician orders did				
		nentation regarding the care				
	and monitoring of the	ne resident's pacemaker.				
	Povious of the Marc	h 2017 MAR did not evidence				
		arding the care and monitoring				
	of the resident' pace					
	Davious of the aliaia	al record did not evidence				
		cardiology consult or that the				
		had been checked.				
	•					
		onducted on 3/16/17 at 12:40 tered nurse) #1, the MDS				
	coordinator. When	asked who had created the				

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

care plan for Resident #19, RN #1 stated she

Eveni IO: 422511

Facility IO: VA0115

If continuation sheet Page 35 of 70

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	ENTERS FOR MEDICARE & MEDICAID SERVICES				C	MB NO. 0938-03	391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY CDMPLETED	
				-		С	
		495261	B. WING	<i>-</i>		03/17/2017	
NAME OF F	PROVIDER OR SUPPLIER			\$T	FREET ADDRESS, CITY, STATE, ZIP CODE		
		25112		12	22 MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND	REHAB		LI	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 CORRECTIDE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION (EACH CONTRACT)	DBE COMPLET	
	Continued From partial had. When asked in a pacemaker, RN is signs and symptom call the doctor." What they should observe should clarify it with should clarify it with should clarify it with should clarify the partial in the partia	inge 35 how staff knew how to care for it stated, "If there are any its that are adverse they should then asked what symptoms it for, RN #1 stated, that they is the doctor. When asked who accemaker care, RN #1 stated, comething missing I would conducted on 3/16/17 at 1:30 insed practical nurse) #4, the sident #19. When asked how accemaker was monitored, LPN is to be checked periodically ardiologist. It could be every ery six months. When asked if ints with a pacemaker, LPN #4. When informed that Resident ints with a pacemaker, LPN #4. When informed that Resident ints with a pacemaker, LPN #4. When informed that Resident where made aware of the inducted with LPN #5 on the informed what symptoms is ident with a pacemaker, LPN is so, syncope (fainting) and ineart beat)." When asked what all these symptoms occur,	<u> </u>	385		RAIL	
	a.m. with ASM #3,	onducted on 3/17/17 at 9:48 the resident's physician. ASM process he follows when a					

resident was admitted with a pacemaker. ASM #3 stated, "Most residents are on demand

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				JIVID NO. C	1930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION].	LETED
		495261	B. WING	s		03/1	7/2017
NAME OF D	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	MOVIDEIX OIX 301 1 EIEX			1	122 MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND	REHAB	_	1	_EESBURG, VA 20176		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	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)	DBE	(X5) COMPLETION OATE
E 30E	Captioned Erom po	ngo 36	E	385	•		
F 385	Continued From pa		1	J00	,		
	pacemakers (1) an	d I talk with the family (about					
	what they want to c	to.) If they're medically stable					
	or asymptomatic de	on't need to check them. If they					
	depend on the pac	emaker we need to check it nonths." When asked how staff					
	know which resides	nts depended on their					
	nacemaker ASM #	#3 stated, "We write it on the					
	orders Lexnect the	em to call for any symptoms					
	but they expect me	to write the order. I'm going to					
	slart a new process	s; it'll be on a separate paper to	ŀ				
	tell them what to do	(with the pacemaker)."					
Į.	3. Resident #2 w	tion was provided prior to exit. as admitted to the facility on Imission on 8/12/16 with					
	diagnoses that incl high blood pressur	uded, but were not limited to, e, dementia, anxiety, osis, and a pacemaker.					
	Resident #2's mos	t recent MDS (minimum data y assessment with an ARD					
	(assessment refer	ence date) of 1/30/17. oded on the BIMS (brief					
	interview of mental	I status) as having a score of					
	10 out of a possible	e 15, indicating that Resident					
		oderately impaired with daily					
	decision making.						
	A review of Reside	ent #2's clinical record revealed, ensive care plan dated 8/12/16					
	that revealed the fo	ollowing documentation;					
	"Problem Onset: 6	6/9/2016. @ (at) RISK FOR					
	CARDIAC COMPL	ICATIONS R/T (related to)					
	CAD (coronary art	ery disease), HTN					
	(hypertension), AN	IGINA PECTORIS (chest pain					
	with exertion), PAC	CEMAKER, Approaches:					
	PACEMAKER CHI FOR IMPAIRED C	ECKS PER ORDER, ASSESS ARDIAC OUTPUT,					

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

DIFFICULTY BREATHING, CHANGE IN SKIN

EvenI ID: 422511

Facility ID: VA0115

If continuation sheet Page 37 of 70

RECEIVED

MAR 3 0 2017

VDH/OL©

PRINTED: 03/22/2017 FORM APPROVED

OF NEEDS COR MEDICARE & MEDICAID SERVICES					OMB N	O. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIOERSUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			IX3) DATE SURVEY	
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	i ' '	ING		OMPLETED	
						С	
		495261	B. WING			3/17/2017	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	Ē		
MEDITA	SE HALL NRSG AND	REHAB		122 MORVEN PARK ROAD NW			
HEKHAU				LEESBURG, VA 20176			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE	
= 005			<u>_</u> _ 1	385			
F 385	Continued From pa		г	000			
	COLOR, LEVEL OF	F CONCIOUSNESS(sic)."					
	Further review of R	lesident #2's clinical record did					
	not reveal any phys	sician notes, physician orders					
	or nursing notes the	at addressed Resident #2's					
	pacemaker.						
	nurse) #1, a unit m	a.m. LPN (licensed practical anager, was asked to provide garding pacemaker orders and for Resident #2.					
	conducted with RN MDS coordinator. responsible for devistated that she was determined what with stated that she won nursing notes, physical assessment) accordingly. RN # Resident #2's care review the care planned for that she would have that Resident #2 had planned for it. RN	0 p.m. an interview was (registered nurse) #1, the RN #1 was asked if she was veloping care plans, RN #1 s. RN #1 was asked how she rould be care planned. RN #1 uld review the hospital records, sician notes and CAA (care triggers and care plan 1 was asked specifically about plan and RN #1 was asked to an. RN #1 was asked why she for a pacemaker. RN #1 stated we seen on the hospital records ad a pacemaker and care #1 was asked to explain what as per order" meant. RN #1					

stated that the nursing staff should have a pacemaker check performed if the resident demonstrated signs and symptoms of pacemaker failure. RN #1 was asked what "order" she was referring to in the care plan. RN #1 stated, "There was no order, it is a generalized care plan to cue the nursing staff." RN #1 was asked if she was a floor nurse what this statement would mean to her. RN #1 stated, "If I read this as a nurse I would contact my physician and ask for

Facility ID: VA0115

PRINTED: 03/22/2017 FORM APPROVED

	MENIOL LIFUTION					OMB NC	0.0938-0391
		& MEDICAID SERVICES	(Y2) MIII	TIDI E C	ONSTRUCTION		TE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		MPLETED
		495261	B. WING			03	C <u>/17/2017</u>
NAME OF F	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL NRSG AND	REHAB			MORVEN PARK ROAD NW		
HERRIAG				LEE	SBURG, VA 20176	10N	1721
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	1X51 COMPLETION DATE
F 385	Continued From pa	_	F	385			
	an order regarding	the pacemaker." RN #1 was d that there was an order					
		maker when she wrote the					
	entry "pacemaker of	checks per order." RN #1					
	stated, "This is star	ndard practice for managing a emaker. If there was no order					
	would (as the MDS	coordinator) bring this to	•				
	nursing's attention	so that they could obtain					
	physician clarificati	on and an order." RN #1 was not she notified the nursing					
	staff that there was	no order. RN #1 stated that					
	she did not.						
	On 3/16/17 at appr	oximately 3:00 p.m. an					
	interview was cond	lucted with LPN (licensed					
·	practical nurse) #1	, a unit manager. LPN #1 not have any further					
	documentation on	Resident #2's pacemaker.					
	LPN #1 was asked	whether or not there should for a pacemaker. LPN #1					
	stated. "Some peo	ple don't get checked. The					
	families may bring	in their own equipment to					
	check and have a	schedule. Some residents go ogists." LPN #1 was asked if					
	there were no disc	harge orders and no family					
	members what wo	uld the nursing staff do					
	regarding the pace	maker. LPN #1 stated, "It's up LPN #1 was asked about)				
	Resident #2's pace	emaker. LPN #1 stated, "She					
	(Resident #2) has	a son, they have a love/hate					
	relationship. The s	son did not bring any nent." LPN #1 was asked					
	whether or not the	physician was contacted					
	regarding pacema	ker orders. LPN #1 stated she	!				
	did not know.						
	On 3/16/17 at app	roximately 4:00 p.m. ASM					

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

(administrative staff member) #2, the director of nursing, provided a history and physical signed by

Event 1D: 422511

Facility ID: VA0115

If continuation sheet Page 39 of 70

RECEIVED MAR 3 0 2017 VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CDNSTRUCTION	(X3) OATE SURVEY COMPLETED
	:	495261	B, WING			C 03/17/2017
	ROVIDER OR SUPPLIER	REHAB		122	REET ADDRESS, CITY, STATE, ZIP CODE 2 MORVEN PARK ROAD NW ESBURG, VA 20176	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 385	hospital discharge and documents had a factor and she conceived and she conceived them. As history and physical stated that she ask afternoon. The hisphysician documer "Pacer check as no symptomatic like of ASM #2 stated that been checked whereview of the dischargarding Resident revealed, in part, the "Cardiac pacemaker has asked whether or robtained from the packed whether or robtained from the packed what shorders on admission pacemaker. RN # know the rate that what to do if the pasked whether or roder for managing that she should. R	date of signature and a summary dated 4/9/16. Both ax date stamp of 3/16/17. If when the documents were onfirmed that she had just the firm of the physician to write it that tory and physical signed by the sted, in part, the following; deded if pt (patient) is it resident #2's pacemaker had in she was in the hospital. A large summary provided in #2's 4/9/16 admission the following documentation; for placement for sick sinus are dysrhythmia) July 2014." If umentation that stated Resident and been checked. ASM #2 was not an order should have been only sician regarding care of the properties of the pacemaker. In an interview was a registered nurse) #3. RN #3 are would do if she did not have on to manage a resident with a 3 stated, "It is important to the pacemaker fails." RN #3 was not she would have a physician of the pacemaker, RN #3 stated in the would do. RN #3 stated in the would do. RN #3 stated it she would do. RN #3 stated		385		

she would call the physician and obtain an order.

PRINTED: 03/22/2017

DELAKTI	ILITE OF TILALITY	MAD HOMMA SELVICES			FORM APPROVED	
CENTERS	FOR MEDICARE	& MEDICAID SERVICES		<u>O</u>	MB NO. 0938-0391	
STATEMENT O AND PLAN OF	F OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	, ,	TPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO	
,		495261	B. WING		C	
NAME OF BB	OVIOER OR SUPPLIER	493201		STREET ACCRESS CITY STATE 7/D COOF	03/17/2017	
NAINE OF PR	O VIOLK OK SUFFLIER			STREET AOORESS, CITY, STATE, ZIP COOE 122 MORVEN PARK ROAD NW		
HERITAGE	HALL NRSG AND I	REHAB		LEESBURG, VA 20176		
(X4) IO PREFIX TAG	(EACH OFFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPE OEFICIENCY)	BE COMPLETION	
F 3 85 (Continued From pa	ge 40	F 3 8	35		
to A rie oo pp A to co co co s A the poor R h p A C fo s	conducted with ASM #3 was asked esident was admitt existing pacemaker in the patient as to acemaker, how off aSM #3 was asked to do. ASM #3 state indicate when it (the hecked and that if ardiac symptoms the hecked and an apparatiology." ASM # taff do if there was as M #3 stated, "It is ne physician. The hysician to write the resident #2. ASM is ave been an order acemaker. The review of the facilities of a Resident was a review of the facilities are of a Resident was a revi	a.m. an interview was M#3, the medical doctor. what his process was when a red to the facility with an a. ASM #3 stated, "It depends how we manage the ten it should be checked." how nursing would know what red, "I would write an order and repacemaker) should be the resident was having hen the pacemaker should be cointment made to a was asked what the nursing no order in the clinical record. It should be in the resident was asked specifically about the as asked specifically about the astated that there should written by him regarding the stypolicy titled "Pacemaker, with a" revealed, in part, the retain; "Monitoring. 5. Make as a medical identification card she has a pacemaker. The				

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

and g. paced rate.

medical record must contain this information as well. Documentation. 1. For each resident with a pacemaker, document the following in the medical record and on a pacemaker identification card upon admission: a) The name, address and telephone number of the cardiologist; b. Type of pacemaker; c. Type of leads; d. Manufacturer and model; e. Serial number; f. Date of implant;

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 41 of 70



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

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CLIVILI	10 I OLL MICHIOLITE	G MEDIO ND CEITVIOLE				***
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	I ' '		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
						С
		495261	B. WING			03/17/2017
NAME OF F	PROVIOER OR SUPPLIER				EET AOORESS, CITY, STATE, ZIP COOE	
HERITAG	E HALL NRSG AND I	REHAB			MORVEN PARK ROAD NW ESBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH OEF[CIENC)	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR OEFICIENCY)	ULO BE COMPLETION
E 385	Continued From pa	nga 41	E	385		,
F 303	Continued From pa	ion was provided prior to the	, ,	300		
	end of the survey p					
F 441		e)(f) INFECTION CONTROL,	F	141		
SS≃F	PREVENT SPREAM	D, LINENS			F 441	
00 1					Corrective Action(s):	ان ورو مود
	(a) Infection preven	tion and control program.			The medical director was n facility failed to implement	
	The feelite and on	tablish an infaction provention			comprehensive infection co	
		tablish an infection prevention (IPCP) that must include, at			and failed to accurately con	
		owing elements:			infection control tracking l	
					Incident & Accident form	
	(1) A system for pre	eventing, identifying, reporting,			completed for each of these	incidents.
		ontrolling infections and			The attending physicians for	or Residents
		ases for all residents, staff, and other individuals			#16 & #17 was notified tha	at the facility
	providing services (failed to initiate isolation p	
		l upon the facility assessment			while be treated for scables	;
	conducted according	g to §483.70(e) and following			The attending physician fo	r Resident #16
		tandards (facility assessment			was notified that a C.N.A.	
	implementation is F	hase 2);			failed to wash her hands pr	
	(2) Written standar	ds, policies, and procedures			the residents room. C.N.A.	
	for the program, wh	nich must include, but are not			inserviced by the DON on contact isolation procedure	
	limited to:	,			washing to be utilized whe	
					residents on isolation preca	
	(i) A system of surv	eillance designed to identify				
		able diseases or infections			The attending physician fo	
	facility;	ead to other persons in the			was notified that RN #5 fa appropriately apply the yel	
	raciiity,				gown prior to delivering c	
	(ii) When and to wh	om possible incidents of			resident's rooms. RN #5 h	as been
	communicable dise	ase or infections should be			inserviced by the DON on	
	reported;				contact isolation procedure	
	responding the state of the	anamicaian banad araggutiana			proper application of the P Protective Equipment to be	
	(iii) Standard and tr	ansmission-based precautions event spread of infections;			assisting residents on isola	
	to be followed to bu	event spread of fileotions,			precautions	
	(iv) When and how	isolation should be used for a			-	

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

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 42 of 70



PRINTED: 03/22/2017

		AND HOWAN SERVICES					APPROVED
CENTER	<u> ₹S FOR MEDICARE</u>	& MEDICAID SERVICES				OWR NO	<u>. 0938-0391</u>
STATEMENT ANO PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	COM	TE SURVEY MPLETED
		495261	B. WING	i		1	C / 17/2017
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
	W 1111) 11200 AND 1	DELLAD		122 1	MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND I	KENAB		LEE	SBURG, VA 20176		
ĮX4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 441	Continued From pa resident; including to (A) The type and du	_	F 4	441			
	depending upon the involved, and (B) A requirement the	e infectious agent or organism hat the isolation should be the sible for the resident under the	·				
	(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and				Identification of Deficient P and Corrective Action(s): All other residents may have been affected. A 100% revie residents with infections will conducted to identify whether	potentially w of all be	
	 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced 				infection requires isolation prand if it was a community ac	recautions quired or a	
					infections will be listed on the control tracking logs to mon- trends, improvement, last cu- organism (if any) and to prev	e infection itor for Iture with vent and	
					control the development of in the facility. Any/all negative related to isolation precaution infection control tracking an	nfections in findings ns and d trending	
					will be corrected at time of c a facility Incident & Accident be completed.	liscovery at it form will	ıd
	document review ar was determined that ensure a complete is control program as residents being treat on the infection con	tion, staff interview, facility nd clinical record review, it at the facility staff failed to infection prevention and evidenced by failure to include ated for an infectious condition atrol tracking logs; and failed					

follow infection control procedures for two of 26

PRINTED: 03/22/2017

		AND RUMAN SERVICES			FORM APPROVED
		& MEDICAID SERVICES	1,000,000	TIDLS CONSTRUCTION	OMB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(XI) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
			A. BUILUI	ING	С
		495261	B. WING		_
NAME OF F	PROVIDER OR SUPPLIER	1 433201		STREET AOORESS, CITY, STATE, ZIP COOE	03/17/2017
NAME OF	PROVIDER OR SUPPLIER			122 MORVEN PARK ROAD NW	
HERITAG	E HALL NRSG AND	REHAB		LEESBURG, VA 20176	
	O. H. O. H. O. T.	TO YOUR OF COMPANY OF		PROVIDER'S PLAN OF CORRECT	TON
(X4) IO PREFIX TAG	(EACH OEFICIENC)	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG		ILOBE COMPLETION
F 441	Continued From pa	ige 43	F 4	41	
	residents in the sur and 16.	vey sample, Resident #s 17,			
	being treated for suan itchy skin condit mite Sarcoptes scalog. 2. The facility staff control policies and contact isolation processident #17 while / contagious conditi 3a. The facility staff control policies and	failed to follow infection procedures and initiate		Systemic Change(s): The facility Infection Control procedure has been reviewed changes are warranted at this DON will be inserviced by th Nurse Consultant on the facil infection control policy and pand the infection tracking log maintaining proper infection standards and prevention in t All staff will be inserviced by and/or Regional Nurse Consultant of Policy to instandard for isolation precautapplication and removal of Policy to a present the approximation.	and no time. The time Regional ity's procedure tips for control the facility. The DON the tall the tions, proper PE and hand
	Resident #16 while / contagious conditi b. The Facility staff after caring for a re #16. c. The facility staff	f failed to sanitize their hands sident in isolation, Resident failed to wear an isolation a caring for a resident in		washing to prevent the sprea infections. Monitoring: The DON is responsible for compliance. The facility has control tracking log for mon tracking infections to mainta compliance. The DON will infection control tracking log review/report all findings to	maintaining s an infection itoring and iin review the g weekly and the Risk
				Management Committee for recommendations. Aggregat	review and te findings of

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

The findings include;

infection control log.

1. The facility staff failed to include residents

contagious condition caused by a mite) on their

A review of the facility infection control log did not reveal the treatment of residents in the facility for suspected infestation of scabies, a highly

being treated for suspected scabies [1] (a

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 44 of 70

the reports will be submitted to the Quality Assurance Committee quarterly

recommendations for change in the

facility policy and procedure.

Compliance Date: 4/28/2017

for review, analysis, and



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0	<u> 391</u>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X I) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495261	B. WING		C 03/17/2017	,
NAME OF PROVIDER OR SUPPLIER HER!TAGE HALL NRSG AND REHAB				STREET ADDRESS, CITY, STATE, ZIP CODE 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		ACTION SHOULD BE COMPLET TO THE APPROPRIATE DATE	NOI
F 441	Continued From pa	ige 44	F	441		

contagious condition caused by a microscopic mite. The infection control log identified only one of three current residents in the facility being treated for scabies as having a skin condition.

On 3/17/17 at 9:30 a.m. an interview was conducted with RN (registered nurse) #6, the infection control nurse. RN #6 was asked to describe her role as the infection control nurse. RN #6 stated that she was responsible for tracking/trending infections and to report any trends of infections. RN #6 further stated that she would follow up on anything appearing "out of the ordinary." RN #6 was asked to provide examples of "infections" that she would be concerned with. RN #6 stated, "C-Diff (clostridium difficile) (a bacterium that causes diarrhea [2]), MRSA (Methicillin-resistant Staphylococcus aureus) (a staph infection that is resistant to several common antibiotics [3]), and any bacterial or viral rash with an unknown etiology." RN #6 was asked what would be done with any of these types of conditions to mitigate the spread of the infection among other residents in the facility and/or staff. RN #6 stated, "Hand washing and isolation." RN #6 was asked if she would need a definitive diagnosis of any condition requiring isolation prior to implementing contact isolation precautions. RN #6 stated, "A condition we have not recognized, but has the potential to spread (among the residents) we would start contact isolation." RN #6 was asked at what point when trending from the infection control log she would be concerned with an outbreak. RN #6 stated, "If I see the infection in more than one person there is the potential." RN #6 was asked how she obtains her information for the infection control log. RN #6 stated that she obtains the information from the 24 hour report that the

PRINTED: 03/22/2017

		AND HUMAN SERVICES			0	MB NO. 0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				
	OF DEFICIENCIES F CORRECTION	JX1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495261	B. WING			C 03/17/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
NEDITA C	E OALL NECC AND I	SELAD		122	MORVEN PARK ROAD NW	1
HERITAG	E HALL NRSG AND I	KEHAD		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 SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
	Continued From panurses do each day treat an infection. Futilized the informat control log. RN #6 be sorted and gives what is happening infections." RN #6 scabies would be a reflected on the infestated that it would condition. At this pot to review the infection the facility current scabies, (Resident reviewed the log and 17 were not on #6 stated that Residentry date was 2/23 "resolved". RN #6 not on the log how tracked and trended hour report and nur asked how the 24 hour report and nur asked how the 24 hoursing). "RN #6 with the information gath and the nurse's not on as a team, from stated, "The informinfection control log review, for QA (quainfection control log	ge 45 y and from any new orders to RN #6 was asked how she sion gathered on the infection stated, "The information can a (us) the ability to analyze in the facility as it relates to was asked whether or not condition that should be ection control log. RN #6 be reflected as a skin bint in time RN #6 was asked on control log for the residents tly receiving treatment for #s 15, 16 and 17). RN #6 dd stated that Residents #16 the infection control log. RN dent #15 was on the log; the was asked if the resident was was asked if the resident was were the incidents of infection d. RN #6 stated, "From the 24 sing notes." RN #6 was nour reports translate to sible outbreak. RN #6 ation is gathered and several at it, the DON (director of DON (assistant director of as asked who was acting on need from the 24 hour report es. RN #6 stated, "It is acted top to bottom." RN #6 ation is conveyed. The is more for our monthly lity assurance). This (the is not our surveillance tool.		441		NATE - STATE -
	The 24 hour report, for that. I do not do	nurse's notes and orders are surveillance." RN #6 was				

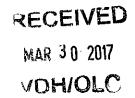
FORM CMS-2567(02-99) Previous Versions Obsolete

asked if she looks at rashes and whether or not she considered that the rashes that were

Event ID: 422511

Facility ID: VA0115

If continuation sheel Page 46 of 70



HEALTH AND HUMAN SERVICES

PRINTED: 03/22/2017

CENTERS FOR MEDICARE & MEDICAID SERVICES ASTREMENT DE GENERICHES NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND REHAB SUMMARY SYMBUST OF DEFICIENCES (EACH DESCRICTION) (X1) DO REPROVIDER OR SUPPLIER TAG SUMMARY SYMBUST OF DEFICIENCES (EACH OPERICAPT VIRILIA TO PROPERTY VIRILIA TO PREFIX TAG CROSS-REFERENCE OT THE APPROPRIATE OF DEFICIENCY) FREETY TAG F. 441 Continued From page 46 currently observed on the 300 hall may be cross contaminated. RN H, 66 stated, "1 think it was considered." At this time ASM (administrative staff member) #2. the director of or unsing, was asked to help clarify the purpose of the infection control log. ASM #2 stated. "The infection control log assessment of the facility document titled, "Introduction infection Control in Long-Term Care" revealed, in part, the following documentation. Surveillance: Surveillance refers to a system for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections and detecting unusual pathogens with infection control implications. Data Analysis: 1. An Infection Prevailons, collects data from the nursing units, categorizes each infection so infections, collects data from the nursing units, categorizes ace infections by body site and records the absolute number of infections. Outbreaks are infrequent but can be potentially most dangerous categories or epidemics and outbreaks are espiratory infections and detecting unusual pathogens with infection control implications. Other potentially most dangerous categories of epidemics and outbreaks are espiratory infections and gastrointestinal infections. Outbreak Management: Infectious and gastrointestinal infections control infections and gastrointestinal infections and outbreaks are espiratory infections and outbreaks are espiratory infections and gastrointestinal infections. Outbreak management infections and outbreaks are espiratory infections and outbreaks are espiratory infections and such pathogens and patho			A MEDICAID CEDVICES					B NO. 0938-0391
NAME OF PROVOER OR SUPPLIER 495261 NAME OF PROVOER OR SUPPLIER HERITAGE HALL NRSG AND REHAB XI 10								
NAME OF PROVIOER OR SUPPLIER HERITAGE HALL NRSG AND REHAB 122 MORVEN PARK ROAD NW LEESBURG, VA. 20176				1 ''			Į(×	COMPLETEO
HERITAGE HALL NRSG AND REHAB 122 MORVEN PARK ROAD NW LEESBURG, VA 2017 REGISTRANCY STATEMENT OF DEFICIENCIES (EACH-DEFE) PROVIDERS PLAN OF CORRECTION (EACH-DEFE) PLAN OF CORRECTION OF CORRECTION (EACH-DEFE) PLAN			495261	B. WING				
LEESBURG, VA 20176 Image: Property of the facility document titled, "Introduction Infection Control in Document detection control program. A review of the facility document titled, "Introduction Infection Control in Document of infections, recording the rounder and detecting outbreaks and epidemics, monitoring employee infections and detecting units, categorizes each infection control implications. Data Analysis: 1. An Infection Preventionist, or someone assigned to perform such functions, collects data from the nursing units, categorizes each infection subtreaks are respiratory infections. Other potentially most dangerous are respiratory infections and gastrointestinal infections. Cher potentially most dangerous are respiratory infections and gastrointestinal infections. Cher potentially most dangerous are respiratory infections and gastrointestinal infections. Cher potentially most dangerous are respiratory infections and gastrointestinal infections. Cher potentially most dangerous are respiratory infections and gastrointestinal infections. Cher potentially import dangerous are respiratory infections and gastrointestinal infections. Cher potentially import dangerous are respiratory infections and gastrointestinal infections. Cher potentially import dargerous are respiratory infections and gastrointestinal infections. Cher potentially import dargerous are respiratory infections and gastrointestinal infections. Cher potentially import dargerous are skin infections. Life to the propertical propert	NAME OF P	ROVIOER OR SUPPLIER			STR	EET AOORESS, CITY, STATE, ZIP CO	OOE	
SUMMARY STATEMENT OF OEFICIENCIES DO PROVIDER'S PLAN OF CORRECTION DATE	UEDITAG	NE LIALL NOOC AND I	DELLAD		122	MORVEN PARK ROAD NW		
F 441 Continued From page 46 currently observed on the 300 hall may be cross contaminated. RN #6 stated, "I think it was asked to help clarify the purpose of the infection control log. ASM #2 stated, "The infection control log is our surveillance tool." ASM #2 was asked whether or not the residents currently being treated for scabies should be on the infection control log. ASM #2 stated, "The infection control log is our surveillance tool." ASM #2 was asked whether or not the residents currently being treated for scabies should be on the infection control log. ASM #2 stated, "The infection control log was requested at this time for the infection control log and the residents currently being treated for scabies should be on the infection control log requested at this time for the infection control program. A review of the facility document titled, "Introduction Infection Control in Long-Term Care" revealed, in part, the following documentation; "Surveillance: Surveillance refers to a system for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections and detecting unusual pathogens with infection control implications. Data Analysis: 1. An Infection Preventionist, or someone assigned to perform such functions, collects data from the nursing units, categorizes each infection by body site and records the absolute number of infections. Outbreaks are infrequent but can be potentially devastating. The two most likely and potentially most dangerous categories of epidemics and outbreaks are respiratory infectionsthat	HERITAG	E HALL NKSG AND I	CENAD		LEE	SBURG, VA 20176		
currently observed on the 300 hall may be cross contaminated. RN #6 stated, "I think it was considered." At this time ASM (administrative staff member) #2, the director of nursing, was asked to help clarify the purpose of the infection control log. ASM #2 stated, "The infection control log is our surveillance tool." ASM #2 was asked whether or not the residents currently being treated for scabies should be on the infection control log. ASM #2 stated, "Yes they should." A policy was requested at this time for the infection control program. A review of the facility document titled, "Introduction Infection Control in Long-Term Care" revealed, in part, the following documentation; "Surveillance: Surveillance refers to a system for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring employee infections and detecting unusual pathogens with infection control implications. Data Analysis: 1. An Infection Preventionist, or someone assigned to perform such functions, collects data from the nursing units, categorizes each infection by body site and records the absolute number of infections. Outbreak Management: Infectious outbreaks are infrequent but can be potentially devastating. The two most likely and potentially most dangerous categories of epidemics and outbreaks are respiratory infections and gastrointestinal infections. Other potentially important categories are skin infectionsthat	PREFIX	(EACH OEFICIENCY	MUST BE PRECEOEO BY FULL	PREF		(EACH CORRECTIVE ACTION : CROSS-REFERENCEO TO THE A	SHOULO BE	E COMPLETION
A review of the facility document titled, "Outbreak of Communicable Diseases" revealed, in part, the following documentation; "Policy Statement:	F 441	currently observed contaminated. RN considered." At this staff member) #2, the asked to help clarify control log. ASM # log is our surveillant whether or not the intreated for scabies control log. ASM # policy was requested control program. A review of the faci "Introduction Infection revealed, in part, the "Surveillance: Survecognizing the occurrecording their numoutbreaks and epid infections and deteinfections and deteinfection control im An Infection Prevento perform such furnursing units, categories and records the infections. Outbreaks are infredevastating. The themost dangerous calculture and the infection control im An Infections outbreaks are respigastrointestinal infections outbreaks are respigastrointestinal infection control in the important categories may spread from in A review of the facion of Communicable Infections.	on the 300 hall may be cross #6 stated, "I think it was stime ASM (administrative he director of nursing, was y the purpose of the infection 2 stated, "The infection control ce tool." ASM #2 was asked residents currently being should be on the infection 2 stated, "Yes they should." A red at this time for the infection this time for the infection with the following documentation; refollowing documentation; refollowing documentation; reformed and frequency, detecting lemics, monitoring employee cting unusual pathogens with plications. Data Analysis: 1. Intionist, or someone assigned anctions, collects data from the gorizes each infection by body a basolute number of ak Management: Infectious quent but can be potentially wo most likely and potentially wo most likely and potentially are sare skin infectionsthat multiple sites. lity document titled, "Outbreak Diseases" revealed, in part, the	F	441			

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

Outbreaks of communicable diseases within the

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 47 of 70



PRINTED: 03/22/2017

		AND HUMAN SERVICES			,	HURM APPRUVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(OMB NO. 0938-0391
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495261	B. WING			C 03/17/2017
NAME OF F	PROVIOER OR SUPPLIER			STF	REET AOORESS, CITY, STATE, ZIP COOE	
urnirac	NE LIALL NOCC AND I	DELLAR		122	MORVEN PARK ROAD NW	
HERITAG	SE HALL NRSG AND I	CUMD		LE	ESBURG, VA 20176	4
(X4) ID PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IÓ PREF TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROOFICIENCY)	O BE COMPLETION
TAG	Continued From particular facility will be prompropriately handle Implementation: 1. communicable disest the following: a. On highly communicable or more cases of the specified period of the Infection Preventuring Services were Receiving surveillar data. c. Completing Tracking Report for A review of the facil "Surveillance for Infection Prevention Surveillance for Heat (HAIs) and other epinfections that have potential resident outransmission-based preventative interverse and Implementation surveillance of infections that have potential resident outransmission-based preventative interverse and Implementation surveillance of infections, to guide to prevent future infine tincluded in routing the service of the control o	ge 47 otly identified and ed. Policy Interpretation and An outbreak of most ases can be defined as one of e case of an infection that is le; c. Occurrence of three (3) e same infection over a time and in a defined area. 8. Intionist and Director of ill be responsible for: a. Ince information and tabulating the Infection Treatment / m, if required.	TAG		CROSS-REFERENCEO TO THE APPRO	
	healthcare environment with serious outbreat Surveillance Data: or designated infect responsible for gath	ment; d. Pathogens associated aks. (e.g. scabies). Gathering 1. The Infection Preventionist ion control personnel is pering and interpreting The Infection Control				

Facility IO: VA0115

Committee and / or QAPI (quality assurance

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0038-0301

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				0	MB NO.	0938-0391
STATEMENT	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 '''		CONSTRUCTION			E SURVEY IPLETEO
		495261	B. WING		-			C 17/2017
NAME OF F	PROVIDER OR SUPPLIER		<u></u>	STR	EET AOORESS, CITY, STATE, ZIP CO	OE	·	
		OF414D		122	MORVEN PARK ROAD NW			
HERITAG	SE HALL NRSG AND I	KEHAB		LEE	ESBURG, VA 20176			
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF OEFICIENCY)	HOULO	BE	tX5) COMPLETION DATE
F 441	Continued From pa	ge 48	F 4	41				
	•	vement) may be involved in						
	No further informati end of the survey p	on was provided prior to the rocess.						
	following website; https://medlineplus. Scabies is an itchy microscopic mite Stall over the world, a spreads quickly in othere is frequent sk people. Hospitals, othomes are example sex partners and ot Sharing clothes, towsometimes spread much more easily worusted scabies. You	gov/scabies.html skin condition caused by the arcoptes scabel. It is common and can affect anyone. Scabies crowded conditions where in-to-skin contact between child-care centers, and nursing as. Scables can easily infect ther household members. wels, and bedding can scabies. This can happen when the infested person has a cannot get scabies from a crent mite infection called						•
	following website; https://medlineplus. s.html a bacterium that ca serious intestinal co disease can also be	was obtained from the gov/clostridiumdifficileinfection uses diarrhea and more onditions such as colitis. The espread in the hospital. The isk. Treatment is with						
	following website; https://medlineplus.	was obtained from the gov/mrsa.html. Infection pping MRSA in hospitals						



PRINTED: 03/22/2017 FORM APPROVED

		AND HUMAN SERVICES			OMB NO. 0938-0391
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	T		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED C
		495261	B. WING	1	03/17/2017
NAME OF F	ROVIDER OR SUPPLIER		. 	STREET ADDRESS, CITY, STATE, ZIP CO	DDE
		OFLIAD		122 MORVEN PARK ROAD NW	
HERITAG	SE HALL NRSG AND	KERAD		LEESBURG, VA 20176	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLETION
F 441	Continued From pa	ge 49	F	441	
	caring for a resident An observation was p.m. of CNA (certifi #4 donned a yellow she then carried Resident the room and set u #4 then went to the gown placed them left the room. CNA before or after carin An interview was cop.m. with CNA #1. Washes their hands after I'm doing a prestaff washed their hiprevent contaminate. An interview was cop.m. with RN (regists supervisor. When a hands, RN #3 states Before doing anyth An interview was cop.m. with CNA #4. Washes their hands enter the room and done." CNA #4 was	onducted on 3/16/17 at 1:45 When asked when staff s, CNA #1 stated, "Before and occedure." When asked why nands, CNA #1 stated, "To ion and exchange infection." onducted on 3/16/17 at 1:30 tered nurse) #3, the evening asked when staff washes their ed, "Before and after care.			

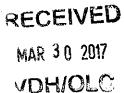
Facility ID: VA0115

If continuation sheet Page 50 of 70

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

caring for Resident #16. CNA #4 stated, "I was thinking about that. I did realize I didn't wash my hands."

Event ID: 422511



PRINTED: 03/22/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0. 0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l ' '		CONSTRUCTION		TE SURVEY MPLETEO
							С
		495261	B. WING			03	/17/2017
NAME OF F	PROVIOER OR SUPPLIER			STF	REET AOORESS, CITY, STATE, ZIP COOE		
				122	MORVEN PARK ROAD NW		
HERITAG	SE HALL NRSG AND I	REHAB		LE	ESBURG, VA 20176		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULO BE	(X5) COMPLETION DATE
F 441	member) #1, the ad	ge 50 p.m. ASM (administrative staff dministrator, and ASM #2, the were made aware of the	F	141			
	the primary means infections. Policy In Implementation. 2. handshaking/hand prevent the spread personnel, resident alcohol-based hand alcohol; or, alternation-antimicrobial) situations: m. After and after entering is settings8. Hand is removing and dispending the property of the property of the primary means a settings8. The hand washing/hand	HAND HYGIENE" facility considers hand hygiene to prevent the spread of terpretation and All personnel shall follow the hygiene procedures to help of infections to other , and visitors. 7. Use an drub containing at least 62% ively, soap (antimicrobial or and water for the following removing gloves; n. before solation precaution hygiene is the final step after osing of personal protective use of gloves does not replace I hygiene. Integration of glove ine hand hygiene is recognized of preventing					
	In Fundamentals of and Wilkins, page washing and the us hands are conduits potential pathogens from a contaminate a staff member to the single most impact and the single most impact and will be single most impact and	ion was provided prior to exit. f Nursing, Lippincott Williams 140-143, concerning hand se of hand sanitizer: "The for almost every transfer of s from one patient to another, ed object to the patient, or from he patient. Hand hygiene is portant procedure in preventing hands are washed with soap					

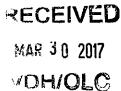
FORM CMS-2567(02-99) Previous Versions Obsolete

before coming on duty; before and after direct or

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 51 of 70



PRINTED: 03/22/2017

		AND HOWAN SERVICES					ORM APPROVED	
CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES						<u>3 NO. 0938-0391</u>	
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 '		CONSTRUCTION	(X:	(X3) DATE SURVEY COMPLETEO	
		495261	B. WING				C 03/17/2 017	
NAME OF I	PROVIDER OR SUPPLIER			STR	EET AOORESS, CITY, STATE, ZIP (COOE		
HERITAC	SE HALL NRSG AND	REHAB			MORVEN PARK ROAD NW ESBURG, VA 20176			
(X4) IO PREFIX TAG	(EACH DEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULO BE		
F 441	indirect patient comadministering medihands with soap affusing hand sanitize alcohol-based hands. Rub hands product has dried (c. Facility staff faile appropriately while isolation, Resident: An observation was RN #5 was observe gown on. RN #5 habehind her neck an the gown and tied ther arms unprotect #5 entered Resider RN #5 stood by the medication to the resident in the next	dact;before preparing or cationsalways wash your per removing gloveswhen r, apply a small amount of the l rub to all surfaces of the together until the entire usually about 30 seconds)." d to wear an isolation gown caring for a resident in	F	141				
	a.m. When asked v was, RN #5 stated, When asked if the s should be on the ar be. When RN #5 w observation, she standn't put the sleev She was aware tha	onducted with RN #5 at 8:48 what the purpose of isolation "To prevent contamination." sleeves of the isolation gown ms, RN #5 stated they should as informed of the above ated she didn't realize she es on the gown on her arms. It the curtain brushed against form. RN #5 stated, "It was an						

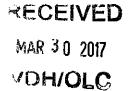
FORM CMS-2567(02-99) Previous Versions Obsolele

On 3/17/17 at 8:50 a.m. ASM #2, the director of

Event IO: 422511

Facility ID: VA0115

If continuation sheet Page 52 of 7D



PRINTED: 03/22/2017 FORM APPROVED

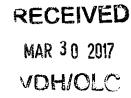
	OF THE LOCATE						D. 0938-0391
		& MEDICAID SERVICES			201070107101		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION		ATE SURVEY DMPLETED
		495261	B. WING			0:	C 3/1 7/ 201 7
NAME OF F	PROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP COD		
HERITAG	E HALL NRSG AND	REHAB			MORVEN PARK ROAD NW SBURG, VA 20176		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 441	Continued From pa nursing was made	ige 52 aware of the findings.	F	441			
	resident's physiciar	onducted with ASM #3, the n. When asked if the resident's igious, ASM #3 stated, "Yes,					
	No further informat	ion was provided prior to exit.					
	control policies and contact isolation pre	failed to follow infection procedures and initiate ecautions when caring for being treated for an infectious on, scabies.					
	1/19/15 with diagnormat limited to, demedegradation of bond	admitted to the facility on uses that included, but were entia, osteoporosis (a e) contractures, agitation, y swallowing) and anxiety.					
	set) was a quarterly (assessment refere Resident #17 was u questions on the BI status) and the staff	st recent MDS (minimum data assessment with an ARD ence date) of 12/13/16. Inable to respond to the MS (brief interview for mental of assessment coded Resident cating that Resident #17's severely impaired.					
	revealed the followi * "1/2/17 Apply 0.2" (corticosteroid for to rash on chest abdo daily) x 5 (five) days	nt #17's clinical record ng physician orders; % (percent) Westcort ointment opical dermatology use.[4]) to men and legs BID (two times s. TO (telephone order) (name Signed by medical doctor and					

dated 1/2/17. FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 422511

Facilily ID: VA0115

If continuation sheet Page 53 of 70



PRINTED: 03/22/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 1		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
		495261	B. WING			C 03/1 7/2017
	PROVIOER OR SUPPLIER GE HALL NRSG AND I	REHAB		122 (EET AOORESS, CITY, STATE, ZIP COOE MORVEN PARK ROAD NW SBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	O BE COMPLETION
F 441	(diagnosis) skin ras medical doctor on 1 * "2/23/17 Permeth apply head to toe o 12 hours. 2 (two) b Scabies." Signed a 2/23/17. * "3/9/17 T.O. FRO IVERMECTIN (and scabies [5]) 3 MG T (tablets) BY MOUT ONE WEEK. V.O. SCABIES." signed on 3/11/17. Further review of R did not reveal an or A review of Resider plan dated 1/19/15 handwritten entries 1/23/17 Rash over Rash. Approaches 3/10/17 Tx (treatmed Be aware of itching the comprehensive isolation. A review of Resider revealed week skin March 10 2017 revealed week skin March 10 2017 revealed the revealed week skin March 10 2017 revealed	ose pak (a steroid) dx sh." Signed and dated by 1/30/17. rin (an insecticide [6]) topical ne time and wash it off after bottles. Dx. (diagnosis) and dated by medical doctor on M (name of medical doctor) oral medication used to treat FABLETS. TAKE 4 TABS H, REPEAT TREATMENT IN (name of medical doctor) DX. and dated by medical doctor desident #17's clinical record receident #17's clinical record revealed, in part, the following ; "1/30/17 Rash all over body. body. 3/10/17. Scabies / sc 2/23/17 Permethrin cream. ent) per order. prednisone. In There were no entries in the care plan related to contact on the #17's clinical record of check forms. An entry on ealed, by diagram, that a rash on her chest, upper and all outer thighs, abdomen and		441		

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

reveal any information related to a diagnosis of scabies and/or the need for contact isolation.

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 54 of 70

RECEIVED
MAR 3 0 2017

VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		TE SURVEY MPLETED
		495261	B. WING	·		03	C 3/ 17/2017
	PROVIDER OR SUPPLIER GE HALL NRSG AND	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		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	JX5J COMPLETION OATE
F 441	Continued From pa	ge 54	F.	141			i
	observed in her roodid not have any incontact isolation gloves observed at Resident #17's roomher bed and was observed by a nurse Resident #17's roomby the nurse to stop without an isolation On 3/15/17 at 5:08 member) #6 (a nurse entering Resident # isolation gown or glostanding against Reflection gown or glostanding against Reflection for the bed. OSM when he exited the interview was conduct as asked if anyone contact isolation. O only one resident or pointed to the room room. OSM #6 was was on contact isolation. On 3/15/17 at 5:20 glassistant) #8 was of (activities of daily liv surveyor maintained with full visibility of the contact was observed not we was observed not we was observed at the contact with full visibility of the contact was observed not we was observed at the contact with full visibility of the contact with full visibility of the contact was observed not we was observed and wa	p.m. Resident #17 was m. The doprway to the room dication that Resident #17 was. There were no gowns or the point of entry into m. Resident #17 was lying in preserved vigorously scratching different face. This surveyor was in the hallway entering mand no attempt was made of this surveyor from entering gown or gloves. p.m. OSM (other staff see aide student) was observed 17's room without any oves. OSM #6 was observed 18's room. At this time an ucted with OSM #6. OSM #6 on the hallway was on SM #6 stated that there was a contact isolation and he opposite to Resident #17's of then asked if anyone else ation. OSM #6 stated "no." D.m. CNA (certified nursing observed providing ADL ing) care to Resident #17, this did a position against the wall CNA #8's activity. CNA #8 rearing a gown and gloves. ed pulling the privacy curtain					

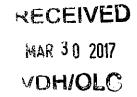
FORM CMS-2567(02-99) Previous Versions Obsolete

around the bed without gloves and also pulled the window curtains closed. CNA #8 put on gloves

Event ID: 422511

Facility ID: VA0115

If continuation sheel Page 55 of 70



PRINTED: 03/22/2017

		& MEDICAID SERVICES			0	MB NO. 09	338-0391	
STATEMENT	OF OFFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
		495261	B. WING	·	•	03/17/	/2017	
NAME OF I	PROVIOER OR SUPPLIER		· · · · · · · · · · · · · · · · · · ·	ST	REET AOORESS, CITY, STATE, ZIP COOE		•	
HERITAG	BE HALL NRSG AND	REHAB			MORVEN PARK ROAD NW ESBURG, VA 20176			
(X4) IO PREFIX TAG	(EACH OFFICIENC)	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	BE C	(X5) OMPLETION OATE	
F 441	Continued From pa	age 55	F	441				
	wiped the perianal with tissues. The swere observed soa with urine. CNA #8 wet diaper in the tra #8 then placed the clear trash bag that the paper towel disobserved to have son her right leg. O Resident #17 and placed clean linen CNA #8 removed hand left the room. when leaving the ro	ved Resident #17's diaper and area with a towel and blotted sheets beneath Resident #17 sked through to the mattress is disposed of the tissues and ash can beneath the sink. CNA soiled linens into a regular, the retrieved from a roll above spenser. Resident #17 was several, round shaped lesions note CNA #8 had cleaned placed a dry diaper on her, he on the bed. Once finished his gloves, opened the curtains He did not wash his hands boom.						
	observed. There we room to indicate the contact isolation.	vas no signage outside the at there was a concern for There were no gowns or gloves try way of the room.						
	observed retrieving storage closet by the put on and then plated aide then entered the	i a.m. a nurse's aide was g an isolation gown from a he nurses station, which she aced gloves on. The nurse's the doorway of the room and a ed the tray to the nurse's aide in						
	conducted with OS pharmacist. OSM ivermectin would b	p.m. an interview was SM (other staff member) #8, the #8 was asked to explain why be prescribed. OSM #8 stated it examples. OSM #8 was asked						

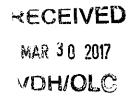
FORM CMS-2567(02-99) Previous Versions Obsolete

how ivermectin would be prescribed/ dosed. OSM #8 stated that generally it would be given

Even| IO: 422511

Facility ID: VA0115

If continuation sheet Page 56 of 70



PRINTED: 03/22/2017 FORM APPROVED

		MEDICAID SERVICES			0	MB NO. 0938-0391
		& MEDICAID SERVICES				(X3) OATE SURVEY
	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	i i		CONSTRUCTION	COMPLETEO
		495261	B. WING			C 03/17/2017
NAME OF F	PROVIOER OR SUPPLIER			STR	EET AOORESS. CITY, STATE, ZIP COOE	
				122	MORVEN PARK ROAD NW	
HER)TAG	BE HALL NRSG AND I			LEF	ESBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH OEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	DBE COMPLETION
F 441	further stated that u but that if a person (itching and continu- be carried over and given "just to be say that the manufactur	ated one week later. OSM #8 isually one dose would suffice continued to be symptomatic and rash) precautions should a second dose would be fe." OSM #8 further stated ters' recommendations stated	F	141		
	scables then dosing days one, two, eigh	as infected with "Norwegian" g would be recommended for t, nine and fifteen with the dosing on days 22 and 29.				
	interview was cond Loudoun County He #7 was asked to de treatment for suspe "The first line of treathe instruction is to and leave on for 12 the linens must be clothing washed an	eximately 1:50 p.m. an ucted with OSM #7, the ealth Department nurse. OSM excribe the recommended ected scabies. OSM #7 stated, atment is Permethrin cream, cover the body head to toe hours, then wash it off. All changed and cleaned, the d bagged and contact isolation or staff members and				
	non-exposed individual completed." OSM: recommendations with the CDC (centers was asked when the complete. OSM #7 a person may still be rash and itching. If symptoms then the retreated. As long itching and a rash, continued. OSM #7 the spread of scabi	duals until treatment has #7 was asked where these were from, OSM #7 stated, of disease control). OSM #7 eatment was considered stated, "Even after treatment be symptomatic, may have a a person persists with treatment should be as a person persists with contact precautions should be 7 was asked how to prevent es. OSM #7 stated, "You have act with those contaminated,				

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

as well as bedding and clothing, or anything else that has been in contact with the infected person."

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 57 of 70

RECEIVED MAR 3 0 2017 **VDH/OLG**

PRINTED: 03/22/2017 FORM APPROVED

OCNTER	OC EOD MEDICADE	S MEDICAID SERVICES			0	MB NO. 0938-0391
		& MEDICAID SERVICES		TID: C 4		(X3) DATE SURVEY
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l ` ′		CONSTRUCTION	COMPLETEO
						C
		495261	B. WING			03/17/2017
NAME OF F	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE	
HEDITAG	E HALL NRSG AND	REHAB			MORVEN PARK ROAD NW	
HENHAG	IL HALL MINOCAND			LEE	ESBURG, VA 20176	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 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 COMPLETION
F 441	Continued From pa	ge 57	F	441		
	OSM #7 was asked	I how staff could determine if				
		successful. OSM #7 stated,				
		the skin and determine if				
	there are any new b	ourrows from the mites."				
	On 3/16/17 of 5:05	p.m. an end of day meeting				
		(administrative staff member)				
		or, ASM #2, the director of				
	nursing and ASM#	3, the regional nurse				
		ministrative staff was asked				
	what reference guid	de they used for the treatment				
	of scables and the	prevention of a scables				:
	policies were based	lity. ASM #2 stated that the				
		ASM #2 was asked why the				
		d with scabies had not been				
	placed on contact is	solation as recommended by				
		partment and the CDC. ASM				
	#2 stated that the ra	ash was a-typical (absent of				
	typical symptoms) a	and therefore they continued to				
	be suspicious of sc	abies but not convinced that ed were actually scabies.				
		ed were actually scaples. n evidence that the first				
		es actually occurred on				
		nt #17. ASM #2 was asked if				
	Resident #17 was p	placed on contact isolation at				
		was not able to state that				
	contact isolation ha	d been put in place. ASM #2				
	stated, "I did not pu	t a cart (isolation) outside of				
		had a choice. We did not diagnosis." ASM #2 was asked				
		was put into place on 2/23/17,				
	ASM #2 stated it wa	as not. A copy of the facility				
	policy for identificat	ion, prevention and treatment				
	of scables was requ	uested at this time.				
i		Scabies" revealed, in part, the				

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

following documentation; Purpose: The purpose of this procedure is to treat residents infected with

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 58 of 70



PRINTED: 03/22/2017 FORM APPROVED

OLIM		A MEDICAID CEDVICES			○ ħ	/B NO. 0938-0391
		& MEDICAID SERVICES	T	TIPLE CONSTRUCTION	I	(X3) OATE SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING		COMPLETED
		495261	B. WING	j		03/17/2017
NAME OF	PROVIDER OR SUPPLIER		<u></u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	
NAME OF	THOUSEN ON BUTT EVEN			122 MORVEN PARK ROAD NW		
HERITA	GE HALL NRSG AND	REHAB		LEESBURG, VA 20176		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IOENTIFYING INFORMATION) TAG		IX (EACH CORRECTIVE ACTION	I SHOULO I	BE COMPLÉTION	
F 441			-	441		
	the spread of scabil Preparation: 2. Re assess for any spe General Guidelines to skin contact with beddin and some furniture remain on Contact (24) hours after trecome into contact with potentially conshould wear a gow protective clothing infection and exposion of 3/17/17 at 9:45 conducted with ASIASM #3 was asked with scabies. ASIA have the ability to prethod by which the scraped and the microscopically), of determines whether with scabies. I look sometimes hard to asked how he wou	les to other residents and staff. view the resident's care plan to cial needs of the resident. 3: 3. Scabies is spread by skin the infected area, or throughing, clothing, privacy curtains 5. Affected residents should Precautions until twenty-four atment. 9. Individuals who with the infected resident or taminated bedding or clothing in and gloves or other as established by the facility's sure control programs. a.m. an interview was M #3, the medical doctor. If how he would treat a resident of the facility is series as a stated, "Since we do not be of the infected area of skin is				

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

applied from the neck down and washed off after 12 hours. In three to four days I would do a second application of lotion. After two

applications, if there is still a rash, I would do a diagnostic test for a positive diagnosis." When asked if these steps had been taken with Resident #17, ASM #3 could only speak to the one application of lotion and one dose of oral medication being administered. There had not been any attempt at a diagnostic test being

EvenI ID: 422511

Facility ID: VA0115

If continuation sheel Page 59 of 70



PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>). 0938-0391</u>		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495261	B. WING			C 3/17/2017		
NAME OF I	PRDVIDER OR SUPPLIER		<u></u>	STREET ADDRESS, CITY, STATE, ZIP C	DDE			
UEDITA.	SE HALL NRSG AND	DEUAR		122 MORVEN PARK ROAD NW				
HERRAU	SE HALL NKSG AND	KENAD		LEESBURG, VA 20176				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE	(X5) COMPLETION OATE		
F 441	prevented spreadin "The staff has to be yellow gowns. Kee separate from othe scabies if you do not Scabies is a contag asked when treatm #3 stated when the treatments have be No further informate end of the survey p [4] This information following website; http://www.rxlist.co The corticosteroids synthetic steroids a anti-inflammatory a [5] This information following website: https://medlineplus tml Ivermectin is also so other roundworm in infestation, and so caused by infestati under the skin). [6] This information following website; https://patient.info/ lear	3 was asked how staff ag scabies. ASM #3 stated, be careful and wear gloves and ap wash cloths and linen ar residemts. You can spread beto twear the gown and gloves. Glous disease." ASM #3 was arent is considered over. ASM aresident is improved and all ben completed. It ion was provided prior to the arcocess. In was obtained from the arcompleted and antipruritic agents and antipruritic agents are was obtained from the all gov/druginfo/meds/a607069.h asometimes used to treat certain affections, head or pubic lice abies (itchy skin condition and was obtained from the		441				
	Permethrin contai (parasites) that live	ns an insecticide. It kills insects e on humans, such as the						

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

scabies mite.

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 60 of 70

MAR 3 0 2017 VDH/OLG

PRINTED: 03/22/2017 FORM APPROVED

	-	O MEDICAID CERVICES			0		938-0391
		& MEDICAID SERVICES	[wo. 1411	TIOL C.C.		(X3) DATE S	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		ONSTRUCTION	COMPL	
		495261	B. WING			03/17	7/2017
NAME OF P	ROVIDER OR SUPPLIER		1	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL NRSG AND	REHAB			MORVEN PARK ROAD NW 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 SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ((X5) COMPLETION OATE
F 441	Continued From pa	ge 60	F 4	141			
	control policies and contact isolation pro	If failed to follow infection procedures and initiate ecautions when caring for being treated for an infectious ion, scabies.					
	1/9/15 with a readministration diagnoses that include	admitted to the facility on nission date of 7/28/16 with uded, but were not limited to, e, atrial fibrillation (an irregular ression.					
	set) was a quarterly (assessment refere Resident #16 was of interview for mental	st recent MDS (minimum data assessment with an ARD ince date) of 1/13/17. coded on her BIMS (brief I status) as scoring 15 out of Resident #16 did not have any					
	revealed, in part, th - 2/23/17 Permethr one time and wash bottles. Dx. (diagno dated by the medical - "3/9/17 T.O. (telepmedical doctor) INV (milligrams) TABLE MOUTH REPEAT II	nt #16's clinical record e following physician orders; in topical apply head to toe it off after 12 hours. 2 (two) esis) Scabies." Signed and al doctor on 2/23/17. Thome order) from (name of /ERMECTIN (sic) 3 MG TS TAKE FOUR TABLETS BY N ONE WEEK. DX. ES." Signed and dated by 8/17/17.					
	revealed, in part, th	nt #16's nursing notes e following documentation;					

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

multiple anti-infection medication including rocephin (an antibiotic), levaquin (an antibiotic)

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 61 of 70

RECEIVED MAR 3 0 2017

VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED

	RS FOR MEDICARE	& MEDICAID SERVICES			ı		0. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495261	B. WING			03	C / 17/2017
	PROVIDER OR SUPPLIER SE HALL NRSG AND I			122	EET ADDRESS, CITY, STATE, ZIP CODE MORVEN PARK ROAD NW SBURG, VA 20176	1 00	71172011
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 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)	LD BE	(X5) COMPLETION DATE
F 441	refused to take med she prefers "Vitamin discussion with MD informed of benefit regimen. Resident referenced medicat attorney) notified. It resident's history to and dated by RN (reinfection control number of the medication for the medication, liver had been administed. A review of Resider plan dated 7/28/16 documentation; "Prescabies/rash. Scramedness, swelling. (treatment) per order of the medication per order of the medication of the medication in the medication in the medication in the medication in the medication for the medication for the medication in the m	ed to treat scabies). Resident dications as prescribed, stating in C powder" and further (medical doctor). Resident of current medication still refused the above sions. MD and POA (power of POA expressed knowledge of refuse treatment." Signed egistered nurse) #6, the rese. esident #16's nursing notes locumentation regarding a diagnosis of scabies or that reactin, used to treat scabies ared. Int #16's comprehensive care revealed, in part, the following oblem/Need: 3/10/17 tches neck, shoulders, chest, Approaches: 3/10/17 Tx er (Ivermectin)." p.m. OSM (other staff se aide student) was observed esident #16's bed; his clothes with the bed. OSM #6 did not en he exited the room. OSM at this time and asked if way was on contact isolation. It there was only one resident and he pointed to the room int #16's room. OSM #6 was e was on contact isolation.	F	441			

Facility ID: VA0115

PRINTED: 03/22/2017 FORM APPROVED OMB NO 0938-0391

CENTERS F	OR MEDICARE	& MEDICAID SERVICES			OMB NO	<u>0. 0938-0391</u>	
		(X1) PROVIDER/SUPPLIER/CLIA (TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495261	B, WING		C 03/17/201		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NRSG AND REHAB				STREET ADDRESS, CITY, STATE, 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	DEFENCIACE TO	CTION SHOULD BE THE APPROPRIATE	(X5 COMPLETION DATE	
F 441 Co	ntinued From pa	ige 62	F	141			

On 3/16/17 at 7:55 a.m. Resident #16's room was observed. There was no signage outside the room to indicate that there was a concern for contact isolation. There were no gowns or gloves observed at the entry way of the room.

On 3/16/17 at 1:20 p.m. an interview was conducted with OSM (other staff member) #8, the pharmacist. OSM #8 was asked to explain why ivermectin would be prescribed. OSM #8 stated it was used to treat scables. OSM #8 was asked how ivermectin would be prescribed/ dosed. OSM #8 stated that generally it would be given once and then repeated one week later. OSM #8 further stated that usually one dose would suffice but that if a person continued to be symptomatic (itching and continued rash) precautions should be carried over and a second dose would be given "just to be safe." OSM #8 further stated that the manufacturers' recommendations stated that if the person was infected with "Norwegian" scables then dosing would be recommended for days one, two, eight, nine and fifteen with the potion of additional dosing on days 22 and 29.

On 3/16/17 at approximately 1:50 p.m. an interview was conducted with OSM #7, the Loudoun County Health Department nurse. OSM #7 was asked to describe the recommended treatment for suspected scabies. OSM #7 stated, "The first line of treatment is Permethrin cream, the instruction is to cover the body head to toe and leave on for 12 hours, then wash it off. All the linens must be changed and cleaned, the clothing washed and bagged and contact isolation is recommended for staff members and non-exposed individuals until treatment has completed." OSM #7 was asked where the

Facility ID: VA0115

PRINTED: 03/22/2017

IOENTIFICATION AND IMPED	OMB NO. 0938-039* IPLE CONSTRUCTION IG
ANO PLAN OF CORRECTION IOENTIFICATION NUMBER: A. BUILOIN 495261 B. WING	COMPLETEO C 03/17/2017 STREET AOORESS, CITY, STATE, ZIP COOE 122 MORVEN PARK ROAD NW
	STREET AOORESS, CITY, STATE, ZIP COOE 122 MORVEN PARK ROAD NW
NAME OF PROVIDER OR SUPPLIER	122 MORVEN PARK ROAD NW
HERITAGE HALL NRSG AND REHAB	LEESBURG, VA 20176
(X4) IO SUMMARY STATEMENT OF OEFICIENCIES IO PREFIX (EACH OEFICIENCY MUST BE PRECEOEO BY FULL PREFIX TAG REGULATORY OR LSC IOENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION 1X51 (EACH CORRECTIVE ACTION SHOULD BE COMPLETION CROSS-REFERENCEO TO THE APPROPRIATE DATE OEFICIENCY)
recommendations were from, OSM #7 stated, "The CDC (centers of disease control). OSM #7 was asked when treatment was considered complete. OSM #7 stated, "Even after treatment a person may still be symptomatic, may have a rash and itching. If a person persists with symptoms then the treatment should be retreated. As long as a person persists with itching and a rash, contact precautions should be continued. OSM #7 was asked how to preventthe spread of scabies. OSM #7 stated, "You have to avoid direct contact with those contaminated, as well as bedding and clothing, or anything else that has been in contact with the infected person." OSM #7 was asked how staff could determine if the treatment was successful. OSM #7 stated, "They could look at the skin and determine if there are any new burrows from the mites." On 3/16/17 at 5:05 p.m. an end of day meeting was held with ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing and ASM #3, the regional nurse consultant. The administrative staff was asked what reference guide they used for the treatment of scabies and the prevention of a scabies outbreak in the facility. ASM #2 stated that the policies were based on the CDC recommendations. ASM #2 was asked why the residents diagnosed with scabies had not been placed on contact isolation as recommended by the local health department and the CDC. ASM #2 stated that the rash was a-typical (absent of typical symptoms) and therefore they continued to	

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

the rashes presented were actually scabies. ASM #2 was shown evidence that the first diagnosis for scabies actually occurred on 2/23/17 for Resident #16. ASM #2 was asked if

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 64 of 70

RECEIVED MAR 3 0 2017 VDH/OLG

PRINTED: 03/22/2017 FORM APPROVED

CENTERS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 09	38-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	IRVEY
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	495261	B. WING		C 03/17/2	201 7
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C		
HERITAGE HALL NRSG AND	REHAB		122 MORVEN PARK ROAD NW LEESBURG, VA 20176		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE CO	JX5J IMPLETION DATE
that time. ASM #2 contact isolation his stated, "I did not pithe door. The staff have a conclusive if contact isolation ASM #2 stated it will policy for identification of scabies was recommended." The facility policy following document of this procedure is and sensitized to state spread of scabies was recommended. The spread of	placed on contact isolation at was not able to state that ad been put in place. ASM #2 at a cart (isolation) outside of had a choice. We did not diagnosis." ASM #2 was asked was put into place on 2/23/17, ras not. A copy of the facility tion, prevention and treatment juested at this time. Scabies" revealed, in part, the station; Purpose: The purpose is to treat residents infected with Garcoptesscabiei and to prevent jues to other residents and staff. Eview the resident's care plan to exial needs of the resident. Secial needs of the resident or the infected area, or through the infected residents should. Precautions until twenty-four reatment. Secial needs or other as established by the facility's sure control programs. Second of the resident or other as established by the facility's sure control programs. Second of the resident or other as established by the facility's sure control programs. Second of the resident or other as established by the facility's sure control programs.	F 4	41		

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

microscopically), observation/clinical diagnosis determines whether or not the person is infected

EvenI ID: 422511

Facility ID: VA0115

If continuation sheel Page 65 pf 70

RECEIVED MAR 3 0 2017 VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CHNIE	RS FOR MEDICARE	- & MEDICAID SERVICES					7141D 14C. 00	00 0001
STATEMENT	OF OEFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING				(X3) OATE SURVEY COMPLETEO	
		1					С	
		495261	B. WING				03/17/	2017
NAME OF I	PROVIOER OR SUPPLIER			STRI	EET AOOF	RESS, CITY, STATE, ZIP COOE		
	STUBLI NECO AND	DELIAR				N PARK ROAD NW		
HERHAC	SE HALL NRSG AND	RENAD		LEE	SBURG	S, VA 20176		
(X4) IO PREFIX TAG	(EACH OFFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		(EAC	ROVIOER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD SEREFERENCEO TO THE APPROPROFICIENCY)	OBE CO	(X5) OMPLETION OATE
F 441	Continued From pa	age 65	F	441				
1 471		k for burrows but it is	•					
	sometimes hard to	diagnose." ASM #3 was						
	asked how he wou	ld treat scabies. ASM #3						
	stated, "First I wou	ld treat with a lotion, it is						
	applied from the ne	eck down and washed off after						
	12 hours. In three	to four days I would do a						
	second application	of lotion. After two						
	applications, it there	re is still a rash, I would do a a positive diagnosis." When						
	asked if these step	s had been taken with						
	Resident #16, ASN	/I #3 could only speak to the						
	one application of	lotion and one dose of oral						
	medication being a	administered; ASM #3 was						
	unable to recall Re	sident #16 refusing the one as documented in the nursing						
	notes There had	not been any attempt at a						
	diagnostic test beir	ng performed. ASM #3 was						
	asked how staff pr	evented spreading scabies.						
·	ASM #3 stated, "T	he staff has to be careful and						
	wear gloves and ye	ellow gowns. Keep wash cloths						
	and linen separate	from other residents. You can						
	spread scables if y	ou do not wear the gown and a contagious disease." ASM						
	gioves. Scaples is	n treatment is considered over.			:			
	ASM #3 stated who	en the resident is improved and						
	all treatments have							
	No further informs	tion was provided prior to the						
	end of the survey					F514		
F 514			F	514		Corrective Action(s):		
SS=D	RECORDS-COMP	LETE/ACCURATE/ACCESSIB				Resident #9's attending phys		
30-0	LE					been notified that the facility		
						to document the non-pharma interventions attempted prior		
	(i) Medical records					administration of a psychoac		
	(1) In accordance	with accepted professional				medication, A facility incide		
	standards and pra-	ctices, the facility must ecords on each resident that				accident form has been comp		i I
	maintain medical r	ecorus un each resident that				incident.		

Facility IO: VA0115

are-

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

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE	& MEDICAID SERVICES				101D 11C. 0930-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495261	B. WING	i		C 03/17/2017			
	PROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	03/11/2011			
NAME OF F	ROVIDER OR SUPPLIER				ORVEN PARK ROAD NW				
HERITAG	E HALL NRSG AND	REHAB			SBURG, VA 20176				
(X4) ID PREFIX TAG	(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)	DBE COMPLETION			
F 514	Continued From pa	ige 66	F	514					
	(i) Complete;	•							
	(ii) Accurately docu	mented;			Identification of Deficient Pr Corrective Action(s):	ractices &			
	(iii) Readily accessi	ible; and			All other residents may have p been affected. A 100% review	of all			
	(iv) Systematically				residents receiving routine or psychoactive medication order	rs and			
	(5) The medical red				MAR's, will be conducted by and/or Unit Manager to identi- at risk for inappropriate docur	fy residents			
	• •	ation to identify the resident;			tions. All fied and/or				
	• •	resident's assessments;			correct at time of discovery. A Incident & Accident form will	time of discovery. A facility			
	provided;	nsive plan of care and services			nding.				
	(iv) The results of any preadmission s and resident review evaluations and determinations conducted by the State				Systemic Change(s): The facility policy and proced been reviewed and no changes warranted at this time. All lice	are ensed			
	(v) Physician's, nurse's, and other licensed professional's progress notes; and				nursing staff will be inserviced DON or regional nurse consul- clinical documentation standar facility policy and procedure.	tant on the rds per			
	services reports as This REQUIREMED by:	iology and other diagnostic required under §483.50. NT is not met as evidenced			inservice will include the stand proper documentation for inter both pharmacological and non pharmacological implemented	dards for rventions -			
	and clinical record the facility staff fails accurate clinical re-	erview, facility document review review, it was determined that ed to maintain a complete and cord for one of 26 residents in			administering psychoactive me	edications.			
	the survey sample, The facility staff fail non-pharmacologic attempted prior to t								

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

psychoactive medication to Resident #9.

Event ID: 422511

Facility ID: VA0115

If continuation sheet Page 67 of 70

RECEIVED

MAR 3 0 2017

VDH/OLC

PRINTED: 03/22/2017 FORM APPROVED OMB NO. 0938-0391

	MEMO OF HEVELL	& MEDICAID SERVICES			0	MB NO. 0938-0391
STATEMENT	OF OEFIC)ENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l ' '		DNSTRUCTION	(X3) OATE SURVEY COMPLETEO
ANOTESTO	. 661.11.427.61.		A. BOILL	,		С
		495261	B. WING	;		03/17/2017
NAME OF F	PROVIOER OR SUPPLIER			STRE	ET AOORESS, CITY, STATE, ZIP COOE	
			ļ	122 N	NORVEN PARK ROAD NW	
HERITAG	E HALL NRSG AND	REHAB		LEES	SBURG, VA 20176	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	TEMENT OF OEFICIENCIES / MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	ΙX	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	O BE COMPLETION
F 514	Continued From pa	ge 67	F	514		·
	The findings include	e:				
	11/26/16 with diagnostic heart disease, and high blood press MDS (minimum dawith an assessment Resident #9 was cound long term mem moderately impaire She was coded as treat anxiety on all period. A review of Resident the following physiciand most recently \$3/13/17: "Xanax (Aanxiety disorders a (milligrams) tablet or some present the solution of th	dmitted to the facility on loses including, but not limited Alzheimer's disease, anxiety, source. On the most recent ta set), a 14-day assessment at reference date of 2/11/17, oded as having both short term nory loss, and as being and for making daily decisions. having received medication to seven days of the look back of the seven days of the look back of the			Monitoring: The DON is responsible for compliance. The DON and/will audit medical records we coinciding with the care plan monitor for compliance. An findings will be clarified and time of discovery and discip will be taken as needed. The this audit will be provided to Assurance Committee for an recommendations for chang policy, procedure, and/or procedure.	or designed eekly n calendar to y/all negative d corrected at slinary action e results of o the Quality nalysis and ge in facility ractice.
	records) for Reside administered accorder on 1/3/17 at 2 1/7/17 at 12:04 a.m 2/14/17 at 2:43 a.m LPN (licensed practite nurses' notes redocumentation on including no descri	Rs (medication administration ent #9 revealed that Xanax was ding to the above referenced 2:44 a.m., 1/4/17 at 12:41 a.m., a., 1/14/17 at 2:58 a.m., a. and 2/19/17 at 3:14 a.m. by tical nurse) #9. A review of evealed no accompanying these dates and times, ption of non-pharmacological apted prior to the administration				

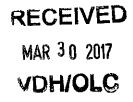
FORM CMS-2567(02-99) Previous Versions Obsolete

On 3/16/17 at 4:05 p.m., LPN #9 was interviewed. She stated that she would give a prn medication

Event IO: 422511

Facility IO: VA0115

If continuation sheet Page 68 of 70



PRINTED: 03/22/2017 FORM APPROVED

DELVIO	MICIAL OF LICYCHIA					•	
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					3 NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495261	B. WING				C 03/17/2017
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		ST	REET ADDRESS, CITY, STATE, ZIP CO	ODE	
	STATE NOOG AND	DELLAD		12	2 MORVEN PARK ROAD NW		
HERMAG	SE HALL NRSG AND	KENAB		LE	ESBURG, 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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	C. ***C
F 514	Continued From pa	age 68	F:	514			
	•	ident who is showing increased					
		ns of anxiety. LPN #9 stated:					
	"I always try other t	things beforehand - either a					
		fer a snack, see if they are in					
		tions before giving them asked where she documents					
		, LPN #9 stated: "In the					
		nen asked about the dates and					
	times referenced a	bove, and informed that there ites for these dates and times,					
		must have just forgotten to					
		s try other things before I give					·
	staff member) #1, t	p.m., ASM (administrative the administrator, ASM #2, the					
		and ASM #4, the regional formed of these concerns.					
		lity policy titled "Charting and vealed, in part, the following:					
		nedications administered,					
	services performed	d, etc., must be documented in					
	the resident's clinic	al records."					
	No further informat	tion was provided prior to exit.					
	(1) "Alprazolam is u	used to treat anxiety disorders					
<u>:</u>	and panic disorder	(sudden, unexpected attacks					
l		d worry about these attacks).					
	Alprazolam is in a c	class of medications called tworks by decreasing					
	abnormal exciteme	ent in the brain." This					
	information is taker	n from the website					
	https://medlineplus	.gov/druginfo/meds/a684001.h					
	tml.						

Facility ID: VA0115

According to Fundamentals of Nursing Made Incredibly Easy, Lippincott Williams and Wilkins,

PRINTED: 03/22/2017 FORM APPROVED

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			0		0938-0391
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	_TIPLE C	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILO	NG		i	PLETED -
		405364	B, WING			1	C 17/2017
NAME OF F	PROVIDER OR SUPPLIER	495261) D. W.1143		EET ADDRESS, CITY, STATE, ZIP CODE	1 03/	1//201/
					MORVEN PARK ROAD NW		
HERITAG	E HALL NRSG AND	REHAB		LEE	SBURG, VA 20176		
(X4) ID PREFIX TAG	(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	1X5) COMPLETION OATE
F 514	Continued From pa	nge 69	F	514			
	Philadelphia PA, pa	ige 23: "Nursing					
	documentation is a	highly significant issue since					
	documentation is a	fundamental feature of nt records are legally valid,					
	and need to be acc	curate and comprehensive so					
	that care can be co	mmunicated effectively to the Inless the content of					
	documentation pro	vides an accurate depiction of					
	patient and family of	care, quality of care may not be	;				
	possible. Many nur	ses do not realize that what ail to record can produce an					
	enormous effect or	n the care that is provided by					
	other members of	the health care team."					
:							

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

Event 1D: 422511

Facility 1D: VA0115

If continuation sheet Page 70 of 70

RECEIVED MAR 3 0 2017 VDH/OLC