PRINTED: 08/25/2016

		AND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,	<u>, , , , , , , , , , , , , , , , , , , </u>	OMB NO. 0938-0391
STATEMENT ANO PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	i	IPLE CONSTRUCTION	IX3) OATE SURVEY COMPLETEO
		495371	B WING		C 08/11/2016
		45371	13	STREET AOORESS CITY STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			120 OLD VIRGINIA AVENUE	
HERITAG	E HALL-RICH CREE	K		RICH CREEK, VA 24147	
(X4) IO PREFIX TAG	(EACH DEFICIENC)	TEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP OEFICIENCY)	DULO SE COMPLETION
F 000	INITIAL COMMENT	rs	F 00	00	,
F 155 SS=D	survey was conducted One complaint was survey. Corrections with 42 CFR Part 4 requirements. The survey/report will form the census in this 106 at the time of the consisted of 19 cure (Residents 1 through reviews (Residents 483.10(b)(4) RIGHTADVANCE DIRECTATION The resident has the refuse to participate and to formulate and specified in paragraph of the facility must conspecified in subpart related to maintaining procedures regarding requirements include provide written informulate and includes a written defined to the resident to the resident of the resident of the resident has the refuse to participate and to formulate and specified in subpart related to maintaining procedures regarding the right or surgical treatment option, formulate and includes a written defined to the resident to t	ne survey. The survey sample rent Resident reviews 19, 19, and 4 closed record 20 through 23). TO REFUSE; FORMULATE FIVES The right to refuse treatment, to a in experimental research, and advance directive as 1, and 1,	F 15	F155 Corrective Action(s): Resident #22 has had the and physician orders reviattending physician and updated and correctly coresident #22's code statuand Accident form was dincident. Identification of Defici Corrective Action(s): All other residents may potentially affected. The Director and/or Social Swill review all resident' to ensure the DDNR is out. Any negative findithe Admission Director Services Director to coresponsible parties to versident's code status a directives to insure that has been explained and notification has been predical record.	they have been impleted to reflect is. An Incident completed for this ent Practice(s) & have been e Admission Services Director is medical records accurately filled ings with result in r and/or Social intact all rerify each and advance it the proper status id that written

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

Facility IE/ VA0206

IX61 DATE

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

PRINTED: 08/25/2016 FORM APPROVED

		& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENT AND PLAN OF CORRECTION	ICIES	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495371	B WING		08/11/2016
NAME OF PROVIDER OF		(1:	TREET ADDRESS, CITY, STATE, ZIP CODE 20 OLD VIRGINIA AVENUE ICH CREEK, VA 24147	
BREELY (FACH	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION

F 155 Continued From page 1

F 155

This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record review, the facility staff falled to ensure the DDNR (Durable Do Not Resuscitate) was complete and accurate for 1 of 23 residents (Resident #22). The findings included:

The facility staff failed to ensure Resident #22's DDNR (Durable Do Not Resuscitate) forms were complete and accurate.

The surveyor reviewed Resident #22's clinical record on 8/11/16. Resident #22 was admitted to the facility 6/22/16 with diagnoses that included but not limited to hepatomegaly, diverticulosis, gallstones, hypothyroidism without goiter, hypercholesterolemia, hypertension, Type 2 diabetes mellitus, gastroesophageal reflux disease, Alzheimer's disease, dementia with behavioral disturbances, cognitive communication deficit, and dysphagia.

Resident #22's 5 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/29/16 assessed the cognitive status as 07 out of 15 in Section C Summary Score. The clinical record contained two (2) Virginia Department of Health Durable Do Not Resuscitate (DDNR) orders both dated 6/22/16 The DDNR forms included in the clinical record read in part.

I further certify (must check 1 or 2):

- 1. The patient is CAPABLE of making an informed decision...
- 2. The patient is INCAPABLE of making an informed decision...

If you checked 2 above, check A, B, or C below: A. While capable of making an informed

Systemic Change(s):

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

Monitoring:

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

Completion Date: 6

PRINTED: 08/25/2016

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					M APPROVED 0. 0938-0391
		& MEDICAID SERVICES	(X 2) MUII.	TIPLE	CONSTRUCTION	(X31 D/	ATE SURVEY
STATEMENT :	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER				CC	OMPLETED
				-			С
		495371	B WING				8/11/2016
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS CITY STATE ZIP COD	Ē	
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HERITAG				KI	CH CREEK, VA 24147	CTION	įX51
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	Cantinued From pa	ige 2	F 1	55	•		1
F 100	Continued From pa	nt has executed a written		-			
	advanced directive.						!
	B While capable	e of making an informed					
	decision, the patien	nt has executed a written					
	advanced directive	which appoints a "Person sent on the Patient's Behalf "					
	C. The patient ha	as not executed a written					
	advanced directive.						
	There were no che-	cks in any of the boxes on					
	either of the DDNR	forms. The section at the R form had been signed by the					
	nhysician and the p	person authorized to consent					
	on the patient's bet 6/22/16.	nalf. The form was dated					
	A review of the adn	nission physician orders dated Resident #22 as "DNR-Do Nol					
	Resuscitate".						
	The surveyor interv	viewed the unit manager					
	licensed practical n	nurse #7 on 8/11/16 at 10:00 showed the unit manager the					
	a.m. The surveyor	ns in the clinical record and					
	questioned who wa	as responsible for their					
	completion. She st	tated she thought admissions					
1		or the completion of the					
	DDNRs. The surveyor infort	med the administrator, the					
	director of nursing	the assistant director of					
	nursing, and the re	igtonel registered nurse of the					
	above finding on 8/	/11/16 at 12:15 p.m.					
	No further informate exit conference on	tion was provided prior to the 8/11/16					
E 226	483.13(c) DEVELO	OP/IMPLMENT	F	226			
SS=D	ABUSE/NEGLECT	, ETC POLICIES					
	The facility must de policies and proced	evelop and implement written dures that prohibit					

		((
DEPARTMENT O	F HEALTH	AND HUMAN SERVICES				PRINTED: 0 FORM AF OMB NO. 0	PPROVED	
CENTERS FOR N STATEMENT OF DEFICIE AND PLAN OF CORRECT	NCIES	& MEDICAID SERVICES [X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE S COMPL	SURVEY .ETEO	
	o cupriler	495371	B WING		STREET ADDRESS, CITY STATE ZIP CODE	_	/2016	
NAME OF PROVIDER OF HERITAGE HALL-		к			20 OLD V)RGINIA AVENUE RICH CREEK, VA 24147			
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F 226 Continue mistreat and mis	ment, neal	age 3 ect, and abuse of residents on of resident property.	d abuse of residents		Corrective Action(s): Contract employee #5 has had checks completed and a crimin	226 Corrective Action(s): Contract employee #5 has had reference hecks completed and a criminal ackground check completed through the Virginia State Police per the policy and I s		
by: Based of review, Virginia, abuse p new em employe	on staff into employee , the facility prevention ployees fo ee #5.	NT is not met as evidenced erview, facility document record review and the Code of staff failed to implement protocol for the screening of r 1 of 5 new employees, new			on-sight at the facility. A fact and Accident for has been conthis incident. Identification of Deficient P Corrective Action(s): All other employees may have potentially affected. The Hint Resources department will an entire amployee records to the potential of the property of the potential of the property of the pr	ractices & re heen han idit 100% of o include		
The fac reference obtain a	ce checks a criminal re	iled to obtain pre-employment per facility policy and failed to ecord check through the			contract employees to identi at risk. Any/all negative find corrected at the time of disc Facility Incident and Accide the completed for any/all neg	overy. A ont Report wil		

Virginia State Police Central Criminal Records Exchange for employee #5.

New employee #5's personnel file was reviewed 8/11/16. Employee #5's application was dated 12/27/15 and hired as a COTA (certified occupational therapy assistant) through the facility's contracting rehabilitation services.

Upon review of the employee file, the surveyor was unable to locate reference checks and the criminal record check obtained through the Virginia State Police Central Criminal Records Exchange.

The surveyor interviewed the regional representative for the contracted rehabilitation professionals (other #3) on 8/11/16 at 10:50. The surveyor requested any information that could provide details of employee #5's references prior

Systemic Change(s):

The facility policy and procedure has been reviewed and no changes are warranted at this time. Administrative Staff, Department Managers and the HR department will be inserviced and issued a copy of the policy & pracedure regarding abase prevention and pre-employment procedures by the Administrator. Administrative Staff and Department Heads extending employment without meeting the requirements of the established facility policy & procedure will receive disciplinary action. Perspective employees will not he allowed to work until all required documentation has been obtained.

PRINTED: 08/25/2016 EODM ADDROVED

DEPARTI	MENT OF HEALTH	AND HUMAN SERVICES		C	MB NO. 0938-0391
STATEMENT C	S FOR MEDICARE OF OEFICIENCIES CORRECTION	& MEDICAID SERVICES IXII PROVICER/SUPPLIER/ICLIA IOENTIFICATION NUMBER	, ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING	
		495371	B WING		08/11/2016
	ROVIOER OR SUPPLIER HALL-RICH CREE		12	REET AODRESS (ZITY STATE, ZIP COOE O OLD VIRGINIA AVENUE CH CREEK, VA 24147	
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TAG	REGULATORY OR C	SCIDENTIFITING INFORMATION			

F 226 Continued From page 4

to hiring as well as the criminal record check through the Virginia State Police.

Other #3 stated the reference checks, he thought, were only written if there was a concern about the employee and stated he thought there was a disclaimer on the application. The surveyor was unable to locate a disclaimer for reference checks on the application. Employee #5 had listed three references on the application. Other #3 provided the surveyor with a "Criminal Justice Information Services (CJIS) Division of the Federal Bureau of Investigation (FBI)" fingerprint submission for employee #5 that was dated 4/7/16. It read "A search of the fingerprints provided by this individual has revealed prior arrest data at the FBI. This does not preclude further criminal history at the state or local level."

The surveyor reviewed the facility's policy for abuse/screening that was requested at the entrance conference on 8/9/16. The policy entitled "Guidelines for the Prevention of Abuse" read in part "Policy: 4. Careful screening of all employees, physicians, and contracted professionals. All information provided by the applicant is verified and at least two references are contacted with documentation maintained in the personnel file."

Excerpt from the Code of Virginia updated September 2014-"Criminal Records-Employment Barrier Crimes-State law (§32.1-126.01 and 32.1-162.9:1 of the Code of Virginia) requires that each...nursing home...obtain a criminal record background check on new hires within 30 days of employment. The law requires that these background checks be obtained using the Central Criminal Records Exchange from the Virginia

F 226

Monitoring:

The Human Resources Manager is responsible for maintaining compliance. The Human Resources Director and/or designee will conduct monthly audits of all new hire employee files for each month to maintain compliance. The administrator will review all audits and report aggregate findings to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. Completion Date: 9/2//6

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

PRINTED: 08/25/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY [X1] PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING __ 08/11/2016 B WING 495371 STREET ADDRESS CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 OLD VIRGINIA AVENUE HERITAGE HALL-RICH CREEK RICH CREEK, VA 24147 PROVIDER'S PLAN OF CORRECTION UX5 SUMMARY STATEMENT OF DEFICIENCIES ıΓt COMPLETION DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION! TAG DEFICIENCY TAG F 226 F 226 Continued From page 5 State Police." The failure of the facility to follow their policy for abuse prevention was brought to the attention of F272 the administrative staff during a meeting on Corrective Action(s): Resident #10 identified in the survey 8/11/16 at 12:15 p.m. sample has had their Care Area Assessment Summary revised to reflect No further information was provided prior to exit the location of the of documentation on 8/11/16. describing the resident's clinical for F 272 F 272 483.20(b)(1) COMPREHENSIVE psychatropic medication use and other SS=D ASSESSMENTS

The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

Identification and demographic information;

Customary routine;

Cognitive patterns;

Communication;

Vision;

Mood and behavior patterns:

Psychosocial well-being:

Physical functioning and structural problems.

Continence;

Disease diagnosis and health conditions;

Dental and nutritional status;

Skin conditions;

Activity pursuit

Medications:

Special treatments and procedures;

Discharge potential;

factors that may impact care planning decisions.

Identification of Deficient Practices & Corrective Action(s):

All other residents may have potentially affected. A 100% review of all Care Area Assessment Summary's will be completed by the RCC and/or designee to identify residents affected. All residents affected will Itave their Care Area Assessment Summary's corrected at time of discover.

Systemic Change(s):

The facility policy and procedure was seviewed and no changes are warranted at this time. The regional nurse consultant will inservice the Resident Care Coordinator's and the interdisciplinary Care Plan Team on accurately completely the Carc Arca Assessment Summary. This will include accurate documentation indicating the date and location of documentation describing each resident's clinical status and other factors that impact care planning.

PRINTED: 08/25/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) OATE SURVEY (XII PROVIOER/SUPPLIER/CLIA IX2) MULTIPLE CONSTRUCTION STATEMENT OF OFFICIENCIES COMPLETEO IDENTIFICATION NUMBER AND PLAN OF CORRECTION A BUILDING __ 08/11/2016 B WING 495371 STREET ACIDRESS CITY STATE ZIPCODE NAME OF PROVIDER OR SUPPLIER 120 OLD VIRGINIA AVENUE HERITAGE HALL-RICH CREEK RICH CREEK, VA 24147 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF OFFICIENCIES IΩ (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION! TAG DEFICIENCY) TAG F 272 F 272 Continued From page 6 Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment Monitoring: The RCC is responsible for maintaining This REQUIREMENT is not met as evidenced compliance. The RCC will complete MDS audit tool weekly coinciding with Based on staff interview and clinical record the MDS calendar to monitor for review, it was determined that the facility staff compliance. Any/all negative findings will be reported to the RCC and the DON failed to ensure a complete and accurate Care at the time of discovery for immediate Area Assessment (CAA) for 1 of 23 Residents in correction. Aggregate findings will be

the sample survey, Resident #10.

The Findings Included: Resident #10 was a 76 year old male who was admitted on 2/8/15. Admitting diagnoses included, but were not limited to: dementia with behaviors, diabetes mellitus, hypertension, anemia and chronic ischemic heart disease The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 7/20/16. The facility staff coded that Resident #10 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #10 required limited assistance (2/2) with Activities of Daily Living (ADL's). In Section N. Medications received 7 days of a psychotropic medication. On August 9, 2016 at 3:35 p.m. the surveyor reviewed Resident #10's clinical record. Review of the clinical record produced signed physician

orders dated 7/2/16. Signed physician orders

reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. Completion Date: 9/21/16

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DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	AND HUMAN SERVICES			FOR	D: 08/25/2016 M APPROVED D: 0938-0391
STATEMENT OF OFFICIENCIES AND PLAN CIF CORRECTION	(X11 PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION NG		ATE SURVEY OMPLETEO C
	495371	B WING			8/11/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREE	K		STREET AOORESS, CITY, STATE, ZIP CO 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	OOE	
(ASTIO	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG	PROVIOER'S PLAN OF COR X IEACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE A OEFICIENCYI	SHOULO BE	IX5) COMPCETION DATE
mg tablet. Take 1 t daily). DX (diagnos Generic: Quetiapin originated on 3/23/ Continued review of an Annual MDS as 2/3/16. The facility had a Cognitive Su facility staff also co required limited (2/ (3/2) with ADL's. In facility staff coded days of a psychotr Care Area Assessi "triggered" for psyc staff failed to docu of CAA documenta	not limited to: "Seroquel 50 ab po BID (by mouth twice es) Dementia with behaviors. e Fumarate." (sic) The order	F 2	72		

On August 9, 2016 at 4:40 p.m. the surveyor notified the MDS Nurse, who was a Licensed Practical Nurse (LPN #2) that Resident #10's CAA Summary was incomplete/inaccurate. The surveyor reviewed the Annual MDS with the ARD of 2/3/16 with the MDS Nurse (LPN #2). The surveyor pointed out that Resident #10 "triggered" for Psychotropic Drug Use. The surveyor also pointed out that the location of the supporting documentation was not documented in the CAA Summary Location and Date of Supporting Documentation. The MDS Nurse (LPN #2) stated, "You are right, it's not there." On August 10, 2016 at 3:55 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure a

record.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				PRINTED: 08/25/2016 FORMAPPROVED DMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETEO
AND PLAN C	FCORRECTION	IOENTIFICATION NUMBER				С
		495371	B WING			08/11/2016
	PROVIDER OR SUPPLIER			120	EET ADDRESS, CITY, STATE, ZIP CODE OLD VIRGINIA AVENUE	
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F 272	Continued From page	age 8	F 2	:72		
	complete and accuracy Resident #10.	rate CAA Summary for				
	to ensure a comple Summary for Resid	as to why the facility staff failed ete and accurate CAA dent #10.	F 2	70	F278 Corrective Action(s):	
F 278 SS=D		RDINATION/CERTIFIED	1 2	.70	Resident #16 has had the quarterly MDS modified coordinator to accurately	by the MDS code section H
	resident's status.	nust accurately reflect the			for the use of a Foley car MDS. A facility Inciden form was completed for	lieter on the
	each assessment participation of hea				Identification of Deficie and Corrective Action(All other residents may be	ent Practice(s) s): nave notentially
	A registered nurse assessment is cor	must sign and certify that the mpleted.			been affected. A 100% a resident assessments will the MDS Coordinator an	idit of all current be completed by d/or designce to
	assessment must that portion of the				ensure that MDS section and coded correctly. All in will be reported to the M for immediate correction.	H is assessed negative findings DS department A Modification
	willfully and knowi	nd Medicaid, an individual who ngly certifies a material and a resident assessment is			will be completed for eac identified on the most cur	h discrepaacy renl MDS.
	subject to a civil m \$1,000 for each as willfully and knowing to certify a material resident assessmon penalty of not more	an income than sees penalty of not more than essessment; or an individual who ingly causes another individual at and false statement in a ent is subject to a civil money to than \$5,000 for each)		Systemic Change(s): The Resident Interdisciptions lieen inserviced by the coordinator on the proper coding of all areas of the I section K of the MDS. AI MDS's and quarterly MD	e MDS assessment and MDS to include comprehensive S's will now be
	assessment Clinical disagreen material and false	nent does not constitute a statement.			reviewed each week accor MDS schedule by the RC Team to ensure the accura of resident data.	ding to the Dand the IDT

PRINTED: 08/25/2016

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FO! OMB 1	RM APPROVED NO. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	I	TIPLE CONCERNICTION		OATE SURVEY
STATEMENT	OF OEFICIENCIES	(XII PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER.		TIPLE CONSTRUCTION		COMPLETEO
ANO PLAN ()	FCORRECTION	IDENTIFICATION NUMBERS	A. BUILDI	NG		С
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		495371	L	STREET ADORESS, CITY, STATE, ZIP CO		00.7.1.2.2
NAME OF F	ROVIOER OR SUPPLIER)	120 OLD VIRGINIA AVENUE		
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HERITAG	E HALL-RICH CREE			RICH CREEK, VA 24147	DECTION	(X5)
(X4) IO PREFIX TAG	FEACH OFFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF COR X IEACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE OEFICIENCY)	SHOULO BE	COMPLETION
	Continued From parties REQUIREME by: Based on staff intereview, it was deterialed to ensure a comminum Data Set in the sample surver The Findings Inclusion Resident #16 was admitted on 7/27/1 included, but were pulmonary effusion hypothyroidism, dehyperplasia (BPH) The most current for located in the clinical and 5 Day Medical Assessment Refered The facility staff concerning to Cognitive Summar also coded that Reasistance (3/3) to Activities of Daily Bladder and Bowethat Resident #16 catheter in the loo On August 11, 201 reviewed Resident of the clinical recommendation of the clinic	age 9 NT is not met as evidenced erview and clinical record rmined that the facility staff complete and accurate (MDS) assessment for 1 of 23 ey, Resident #16. ded: a 93 year old male who was 6. Admitting diagnoses not limited to: rib fracture, n, pneumothorax, hypertension, ementia and benign prostatic. Minimum Data Set (MDS) cal record was an Admission re MDS assessment with an rence Date (ARD) of 8/3/16. oded that Resident #16 had any Score of 8. The facility staff esident #16 required extensive total nursing care (4/3) with Living (ADL's). In Section H. It the facility staff did not code had an indwelling Foley k back period of 7 days. If at 8:30 a.m. the surveyor t-#16's clinical record. Review and produced a hospital ery dated 7/27/15 that Resident #16 had: "10. BPH hypertrophy) -No urinary we home meds as note dated 7/27/16. The as note documented: "Benign ery modern and complete in the clinical record produced a service of the clinical record produced as note dated 7/27/16. The as Note documented: "Benign ery modern and complete in the clinical record produced a service of the clinical record pro			MDS explicted MDS calenda III negative be reported time of rection. eported to the ee nionthity e in facility	
	Prostatic Hypertro	ophy without obstruction Will		Facility IO 1/40205	f continuation	sheet Page 10 of

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			FORM APPROVED OMB NO. 0938-0391
CENTER STATEMENT	RS FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	1	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETEO
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NAME OF F	PROVIOER OR SUPPLIER		·	STREET ADORESS, CITY, STATE, 2	ZIP COOE
	SE HALL-RICH CREE	K		120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	
(X4) IO PREFIX TAG	SUMMARY STA	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREF TAC	PROVIDER'S PLAN OF	TION SHOULO BE COMPLETION THE APPROPRIATE OATE
F 278	Continued From pa	age 10	F	278	
	when we can." (sic Continued review of nursing notes: "7/2 (French) catheter if yellow urine " (sic The Foley cathete at 2 p.m. The surveyor note not coded on the AMDS with the ARD On August 11, 201 a.m. the surveyor was a Licensed Property of the surveyor was a Licensed Property of the surveyor notif that when Resident #16's Ad MDS was inaccurated that when Resident facility the indwelling Foley of the surveyor notif that when Resident facility the indwelling place. The survey with the MDS Nurse (Lout that the MDS Nurse (Lout that the Foley Section H. The Mishe did not code On August 11, 20 team met with the of Nursing (DON) (ADON) and the (CCN). The surveyor that the surveyor the surveyor that the foley Section H. The Mishe did not code (CCN). The surveyor that the foley that the surveyor that the foley that the	of the clinical record produced 18/16 12:10 AM16 f in place and draining dark ic). In was discontinued on 7/29/16 of that the Foley catheter was admission and 5 Day Medicare of 8/3/16. If a far ya.m. the surveyor at 9 notified the MDS Nurse, who rectical Nurse (LPN #8), that mission and 5 Day Medicare etc. The surveyor notified the #8) that Resident #16 had an eatheter while in the hospital. Fied the MDS Nurse (LPN#8) at #16 was admitted into the ing Foley catheter was still in yor reviewed the clinical record se (LPN #8). The surveyor is note and the nursing notes. In reviewed the Admission and 5 with the ARD of 8/3/16 with PN:#8). The surveyor pointed catheter was not coded in IDS Nurse (LPN #8) stated.			
	Admission and 5	Day Medicare MDS assessmer		Facility IO: VA0206	If continuation sheet Page 11 of

PRINTED: 08/25/2016

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				FORM	APPROVED . 0938-0391
CENTER	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES IX11 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	1		DISTRUCTION	(X3) DATE SURVEY COMPLETED C 08/11/2016	
ANDIDATE		495371	B WING				
	ROVIDER OR SUPPLIER E HALL-RICH CREE	K		120	ET ADDRESS, CITY, STATE, ZIP CODE DLD VIRGINIA AVENUE I CREEK, VA 24147		
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI JEACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCYI	.DBE	(X5) COMPLETION DATE
F 278	Continued From pa	3/16.	F 2	 278			
F 279 SS≒D	On additional information of the facility at the ensure a complete assessment for Ref 483.20(d), 483.20(d).	mation was provided prior to as to why the facility staff failed at and accurate MDS asident #16. k)(1) DEVELOP	F2	279			
	to develop, review comprehensive plate The facility must deplan for each residual plan for each residual pursing a medical pursing a	the results of the assessment and revise the resident's an of care. evelop a comprehensive care lent that includes measurable etables to meet a resident's and mental and psychosocial ntified in the comprehensive			F 279 Corrective Action(s): Resident #10's comprehensive care has been reviewed and revised to re appropriate goals and interventions approaches to address the resident's Urinary Incontinence status that wa triggered on the Care Area Assesson Summary (CAA's). A Facility Inci	and s s nent dent &	
	to be furnished to highest practicable psychosocial well- §483.25; and any be required under	st describe the services that are attain or maintain the resident's e physical, mental, and being as required under services that would otherwise §483.25 but are not provided it's exercise of rights under the right to refuse treatment (4).	; ;		Accident Form was completed for incident. Identification of Deficient Practice Corrective Action(s): All other residents may have potent been affected. A 100% review of a comprehensive care plans will be conducted by the RCC and/or desidentify residents with inaccurate incomplete care plans. Resident is inaccurate or incomplete care.	ces itially all ignee to or dentified e plans	
	by: Based on staff in review, it was det	ENT is not met as evidenced terview and clinical record ermined that the facility staff a Comprehensive Care Plan Residents in the sample survey	y ,		will have their care plan reviewed updated to reflect their current interventions and appropriate appropriate approaches. A Facility Incident & Acc Form will be compteted for each	oroaches ment	

The Findings Included:

failed to develop a Comprehensive Care Plan (CCP) for 1 of 23 Residents in the sample survey, Resident #10.

identified.

PRINTED: 08/25/2016 FORM APPROVED

DEPARTMENT OF REAL	THAND HOWAN SERVICES		0	MB NO. 0938-0391
STATEMENT OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) OATE SURVEY
AND PLAN OF CORRECTION	IOENTIFICATION NUMBER:	1	ING	COMPLETED
				C-
	495371	B. WING		08/11/2016
NAME OF PROVIDER OR SUPPLIE	ER .		STREET AOORESS, CITY, STATE, ZIP COOE	
TELL T		}	120 OLD VIRGINIA AVENUE	
HERITAGE HALL-RICH CRI	EEK		RICH CREEK, VA 24147	
FACH OFFICIE	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFI TAG		BE COMPLETION
F 279 Continued From	page 12	F 2	279	
Resident #10 wa	s a 76 year old male who was	•		
admitted on 2/8/	15. Admitting diagnoses			
included, but we	re not limited to: dementia with			• •
behaviors, diabe	tes mellitus, hypertension,			
anemia and chro	nic ischemic heart disease.		Systemic Changes:	
The most curren	t Minimum Data Set (MDS) ited in the clinical record was a		The facility Policy and Procedure h	as
Ouerterly MDS a	ssessment with an Assessment		been reviewed and no changes are warranted at this time. The nursing	
Reference Date	(ARD) of 7/20/16. The facility		acceptiful Drocess as anidom - 11	.4
staff coded that I	Resident #10 had a Cognitive		- 1 10013 REDOTT and doors and a	•
Summary Score	of 13. The facility staff also		THE THEOLOGICAL LECTURAL SHAPE PRINCIPLE	ders
coded that Resid	lent #10 required limited		" " VC USCU III DEVELOR and!	
assistance (2/2)	with Activities of Daily Living on H. Bladder and Bowel the		comprehensive plans of care. The Regional Nurse	CC -
(ADL's), In Secu	d that Resident #10 was		**************************************	
"Occasionally In	continent" of bladder and bowel.		developinent and tinnlementation	200
On August 9, 20	16 at 3:35 p.m. the surveyor		of individualized care plans.	20022
reviewed Reside	ent #10's clinical record. Review		Monitoring:	
of the clinical rec	ord produced an Annual MDS		The RCC and DOM	
assessment with	the ARD of 2/3/16. The facility		The RCC and DON are responsible f maintaining compliance. The DON a	
staff coded that	Resident #10 had a Cognitive			
Summary Score	of 15. The facility staff also dent #10 required limited (2/2) to			
coded that Resid	ance (3/2) with ADL's. In Section			tive
H Bladder and E	Sowel the facility staff coded that			
Resident #10 wa	as continent of bladder and bowel		and/or RCC for immediate correction. Detailed findings of the interdiscipling team's audit will be an	•
However in Sec	tion V. Care Area Assessment			
Summary (CAA'	s) Resident #10 "triggered" for		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	CIL
Urinary Inconting	ence/Rehabilitation Potential.		"" U SISI AUD I COntimendati c	cw,
The facility staff	documented to see the		change in facility policy, procedure	
supporting docu	mentation in the "adl sheet le facility staff documented that a		and/or practice. Completion Date: 9/7///6	
2/3/10. (SIC) 11	be developed to address		Completion Date: 9/1///	
Resident #10's U	Jrinary		()	
Incontinence/Re	habilitation Potential.			

Facility IO: VA0206

Continued review of the clinical record produced

the Comprehensive Care Plan (CCP) dated 2/4/16. Review of the CCP failed to produce a care plan that addressed Resident #10's Urinary

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				RINTED: 08/25/2016 FORM APPROVED MB NO. 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES FORRECTION	& MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	i		CONSTRUCTION	(X3) OATE SIJRVEY COMPLETEO
		495371	8 WING			C 08/11/2016
NAME OF P	ROVIOER OR SUPPLIER			l	EET AOORESS, CITY, STATE, ZIP COOE OLD VIRGINIA AVENUE	
HERITAG	E HALL-RICH CREE	K		RIC	H CREEK, VA 24147	
(X4) IO PREFIX TAG	/EACH OFFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTIO IEACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROP OEFICIENCY)	DIBE COMPERTION
	O claved From po	ngo 13	F:	279		
F 279	Continued From pa	bilitation Potential.	, -			
	On August 9, 2016	at 4:40 p.m. the surveyor				!
	Practical Nurse (Lf	lurse, who was a Licensed PN #2) that Resident #10's did				
1	not have a CCP T	The surveyor reviewed the	į			
	Nurse (LPN #2) T	he ARD of 2/3/16 with the MDS he surveyor pointed out				
	Section V CAA's.	The surveyor pointed out that				
	Resident #10 "trigg	abilitation Potential and that the				
	facility had docume	ented that a care plan would be				
	developed for Res	ident #10's Urinary abilitation Potential. The				
	surveyor notified th	he MDS Nurse (LPN #2) that a				
	care plan could no	it be located to address				
	Resident #10's Uri	abilitation Potential. The MDS				
	Nurse (LPN #2) re	viewed the CCP and could not				
	locate a care plan	that addressed Resident #10's ncontinence/Rehabilitation				
	Potential		•			
	On August 10, 201	16 at 3:55 p.m. the survey team nistrator (Adm), Director of				
	Nursing (DON) As	ssistant Director of Nursing				
į	(ADON) and the C	Corporate Compliance Nurse				
	(CCN). The surve	eyor notified the Administrative e facility staff failed to develop a	ì			
	CCP to included (Urinary				
	#10	abilitation Potential, for Resider				
	No additional infor	rmation was provided prior to				
	exiting the facility to develop a CCP	as to why the facility star falled				
F 280 SS=D	400 00(4)(3) 483	10(k)(2) RIGHT TO ANNING CARE-REVISE CP	F	280		

PRINTED: 08/25/2016 **FORM APPROVED** OMB NO. 0938-0391

CENTERS FOR MEDICAR	E & MEDICAID SERVICES		LYN DATE CURVEY
STATEMENT OF OFFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY
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ANO PLAN OF CORRECTION	IOZIVIII IO III IO	A BUILDING	
	495371	B WING	08/11/2016
		STREET AOORESS, CITY, STATE, ZIP COOE	
NAME OF PROVIOER OR SUPPLIES	₹		

HERITAGE HALL-RICH CREEK

120 OLD VIRGINIA AVENUE

RICH CREEK, VA 24147

PRÉFIX TAG

SUMMARY STATEMENT OF OFFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

10 PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)

IX5: COMPLETION OATE

F 280 Continued From page 14

incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced

Based on observation, staff interview and clinical record review, the facility staff failed to review and revise the current comprehensive care plan for 1 of 23 residents (Resident #6). The use of Bilateral ulnar drift splints for Resident #6 had not been placed on the current comprehensive care plan.

The findings included:

The facility staff failed to revise Resident #6's current comprehensive care plan to incorporate the use of bilateral ulnar drift splints at bedtime.

Resident #6 was admitted to the facility 5/6/14 and readmitted 12/27/15 with diagnoses that included but not limited to rheumatoid arthritis, F 280

F-280

Corrective Action(s):

Resident 6's comprehensive care plan has been reviewed and revised to reflect the resident's use of bilateral ulnar drift splints at bedtime. A Facility Incident & Accident Form was completed for this incident.

Identification of Deficient Practices & Corrective Action(s):

All other residents with physician ordered splinting equipment may have potentially been affected. A 100% review of all comprehensive care plans for residents with splinting devices will be conducted by the RCC's and/or designee to identify residents at risk. Residents identified at risk will have their comprehensive care plans updated and revised to reflect their currents needs and interventions to meet their resident specific care needs to prevent or minimize any further weight loss. A facility Incident & Accident Form will be completed for each incident identified.

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ł	OVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	
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F 280 Continued From page 15

chronic obstructive pulmonary disease, hypertension, atherosclerotic heart disease, hypokalemia, gastroesophageal reflux disease, hypercholesterolemia, depressive disorder, nutritional anemia, and anxiety.

Resident #6's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 6/29/16 assessed the resident with a brief interview for mental status as 09 out of 15.

The most recent signed physician orders were July 2016. The orders included for staff to apply (B) ulnar drift splint daily and remove (B) ulnar drift splint daily.

The surveyor observed Resident #6 numerous times during the survey without the splint-8/10/16 at 7:35 a.m. while in bed, 8/10/16 at 8:30 a.m. uo in wheelchair eating breakfast, and 8/10/16 at 9:48 a.m. during a wound care observation.

The surveyor requested the current comprehensive care plan for Resident #6. The current comprehensive care plan dated 7/1/16 identified the problem of ADL (activities of daily living) Function/Dental. Resident #6 needs assistance with ADLs. He has contractures to his hands due to Rheumatoid Arthritis. He is up in a wheelchair daily which he self-propels with his feet. He is edentulous and does not wear dentures. Approaches: Provide shower/whirlpool 2 times a week and as needed, shave facial hair daily, provide daily dressing and grooming, assist with mouth care daily, provide good peri-care every 2 hours and as needed, keep skin clean and dry at all times, provide dressing and grooming with seasonal clothing, and therapies per md (doctor) order.

F 280

Systemic Changes:

The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process and the interdisciplinary team is responsible for managing the process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record, and physician urders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-services to the RCC and care plan team on the mandate to develop individualized care plans within 7 days of the enmpleting and/or revisions to the comprehensive assessment and as indicated with any changes in condition.

Monitoring:

The RCC and DON will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan schedule. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 9/2///

THE WEALTH AND HUMAN SERVICES

PRINTED: 08/25/2016 FORM APPROVED

DEPART	MENT OF HEALTH	AND HOMAN SERVICES				MB NO. 0938-	<u>-0391</u>
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVI	
AND PLAN DE	CORRECTION	IDENTIFICATION NUMBER.	A BUILL	DING _		С	
		495371	B WING			08/11/201	16
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
		ĸ		ļ	OLD VIRGINIA AVENUE		
HERITAG	E HALL-RICH CREE			L	PROVIDER'S PLAN OF CORRECTION	ON: 1)	K5
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F 280	Continued From pa	age 16	F	280			
	staff in the use of t	lan did not direct the nursing he splints (when to apply, w to long to apply, and when to ent #6.					
	licen sed practical r p.m. L.P.N. #9 sta staff applied the sp moving during the to remove them. T	viewed the unit manager nurse #9 on 8/10/16 at 3:30 lted she thought the night shift plints because he was up and day and would be more likely the August 2016 treatment wed and splints were they were applied and					
	(MDS) licensed pr L.P.N. #2 stated si be on the care pla L.P.N. #2 on 8/11/ stated the use of s	viewed minimum data set actical nurse #2 on 8/10/16. he didn't think splints needed to n. The surveyor re-interviewed 16 at 8:00 a.m. L.P.N. #2 splints had been placed on the ed "They had been)				
	director of nursing	rmed the administrator, the , the assistant director of gional registered nurse above finding on 8/11/16 at					
F 309 SS=D	exit conference or	CARE/SERVICES FOR	F	⁻ 309			
	Each resident mu provide the neces	st receive and the facility must sary care and services to attain	n				

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DELYMPIA DE MEDIOADE	O MEDICAID SEDVICES		_O	MB NO. 0938-039 I
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1 PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.			IX3) DATE SURVEY COMPLETED
	495371	B WING		08/11/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREE			STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	
/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ARROS RECEDENCED TO THE APPROP	D BE COMPLETION

F 309

F 309 Continued From page 17

or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record review, facility staff failed to follow physician's orders for medication administration for 2 of 23 residents in the survey sample (Residents #12 and #19).

1. For Resident #12, facility staff failed to administer Culturelle for 30 days as ordered

Resident #12 was admitted to the facility on 6/22/15 with diagnoses including hypertension, dementia, coronary artery disease, and obstructive uropathy. On a quarterly minimum data set (MDS) assessment with assessment reference date 6/15/16, the resident was assessed with long and short term memory impairment, moderate impairment in ability to make daily choices, scored 2/8 for signs of delinum, and was assessed with daily wandering.

During clinical record review on 8/10/16, the surveyor noted a physician order on 7/8/16 for Culturelle 2 capsules by mouth daily at bedtime for 30 days. The medication administration record documented the medication administered 7/9/16 through 8/7/16, for a total of 29 doses. There were medication or nurse's notes concerning the shortage.

The surveyor discussed the shortage with the

F309

Corrective Action(s):

Resident #12's attending physician was notified that the facility staff failed to administer Culturelle for 30days as ordered by the attending physician. A facility Incident and Accident form was completed for this incident.

Resident #19's attending physician was notified that the facility staff failed to administer Zocor as ordered by the physician. A facility Incident and Accident form was completed for this incident.

Identification of Deficient Practices/Corrective Action(s): All other residents may have heen potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and the attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	,		<u>O</u>		0938-0391
STATEMENT	OF OEFICIENCIES OF CORRECTION	(XI) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER	l .		ONSTRUCTION		E SURVEY PLETEO
] (С
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NAME OF F	PROVIOER OR SUPPLIER			STRE	ET AOORESS, CITY, STATE, ZIP COOE		
				120	OLD VIRGINIA AVENUE		
HERITAG	E HALL-RICH CREE	К		RIC	H CREEK, VA 24147		
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F 315	acknowledged the The shortage was a meeting with the act and a corporate co. 2. For Resident #1 administer Zocor or physician. Resident #19 was a 7/29/16 with diagnor hernatoma, peripher fibrillation, and ben the admission minit assessment with as 8/5/16, the resident interview for menta without signs of del During clinical reconsurveyor noted a proper for Zocor 40 milligramedication administered 8/1/16 surveyor was unab extra dose in the Month of the Surveyor discursing and administing on 8/11/16 483.25(d) NO CAT	on 8/10/16. The DON resident received 29 doses. discussed during a summary dministrator, director of nursing insultant on 8/10/16. 9, facility staff failed to ne time daily as ordered by the admitted to the facility on oses including subdural eral artery disease, atrial ign prostatic hypertrophy. On mum data set (MDS) is sessment reference date it scored 13/15 on the brief of status, and was assessed dirium or psychosis. For direview on 8/11/16, the hysician order dated 7/29/16 am tablet by mouth daily. The stration record (MAR) for mented Zocor 40 mg at 9 AM and 9 PM. The let to locate reference to the IAR or nurse's notes. Instatus, and was assessed the error with the director hinistrator during a summary is. HETER, PREVENT UTI.		309	Systemic Change(s): Facility policy and procedures liaving reviewed. No revisions are warranthis time. The nursing assessment is sevidenced by the 24 Hour Report documentation in the medical recomplysician orders remains the source document for the development and monitoring of the provision of carrinchides, obtaining, transcribing and completing physician medication treatment orders. The DON and/or Regional nurse consultant will insuall licensed staff on the procedure obtaining, transcribing, and complete physician ordered incdication and treatment orders. Monitoring: The DON is responsible for maintenance. The DON, ADON and Unit Managers Ivill audit all MAFI (veckly to monitor for compliance Any/all negative findings and or exill be corrected at time of discondisciplinary action will be taken a needed. Aggregate findings of the audits will be reported to the Quanced Assurance Committee quarterly for change in facility policy, procedured/or practice. Completion Date: 4/1/1/	ted at process rt and rd and e in the control of th	
F 315 SS=D	483.25(d) NO CAT RESTORE BLADD	HEIER, PREVENTUH, HER	1.	510			

Facility IO: VA0206

Based on the resident's comprehensive assessment, the facility must ensure that a

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

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STATEMENT	OF	OEF	ICIEN	CIES
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(X2) MULTIPLE CONSTRUCTION	
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IX3) OATE SURVEY COMPLETEO

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08/11/2016

NAME OF PROVIDER OR SUPPLIER

HERITAGE HALL-RICH CREEK

STREET AOORESS CITY, STATE, ZIP COOE
120 OLD VIRGINIA AVENUE

RICH CREEK, VA 24147

PROVIDER

PROVIDER'S PLAN OF CORRECTION IEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY) JX5J COMPLETION DATE

F 315 Continued From page 19

resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

SUMMARY STATEMENT OF OFFICIENCIES

(EACH OEFICIENCY MUST BE PRECEDED BY FULL

REGULATORY OR LSC IDENTIFYING INFORMATION)

This REQUIREMENT is not met as evidenced by

Based on staff interview and clinical record review, it was determined that the facility staff failed to obtain physician orders for necessary indwelling catheter (Foley catheter) for 1 of 23 in the sample survey, Resident #16.

The Findings Included:

Resident #16 was a 93 year old male who was admitted on 7/27/16. Admitting diagnoses included, but were not limited to: rib fracture, pulmonary effusion, pneumothorax, hypertension, hypothyroidism, dementia and benign prostatic hyperplasia (BPH).

The most current Minimum Data Set (MDS) located in the clinical record was an Admission and 5 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 8/3/16. The facility staff coded that Resident #16 had a Cognitive Summary Score of 8. The facility staff also coded that Resident #16 required extensive assistance (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).

On August 11, 2016 at 8:30 a.m. the surveyor reviewed Resident #16's clinical record. Review of the clinical record produced a hospital Discharge Summary dated 7/27/16 that documented that Resident #16 had: "10. BPH (benign prostatic hypertrophy) -No urinary

F 315

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F315

Corrective Action(s):
Resident #16's attending physician was notified that the facility failed to obtain Fnley Catheter care orders upon admission to the facility. A facility Incident & Accident report has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):

All other residents with a Folcy Catheter may have potentially been affected. The DN, ADON or Unit Manager will review 100% of residents with a Folcy Cather to ensure each resident has specific Folcy catheter orders. Any/all negative findings identified will be corrected at the time of discovery. A facility Incident & Accident Form will be completed for each incident identified.

Systemic Change(s):

Reviewed current facility policy and procedure, no changes warranted at this time. All nursing will be inserviced by the DON ad/or ADON on the proper Follow catheter care orders to be implemented for all residents with a physician ordered Follow Catheter. To include Follow size, Bulb size, treatment to be provided if dislodged or clogged as well as routine daily care.

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		AND HUMAN SERVICES				FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495371	B. WING	i		08/11/2016
NAME OF	PROVIDER OR SUPPLIER			ş	TREET ADDRESS, CITY, STATE, ZIP CODE	
}				1/	20 OLD VIRGINIA AVENUE	
HERITAG	BE HALL-RICH CREE	K		R	NCH CREEK, VA 24147	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
TAG	Continued From pa symptoms -continu (medications)-keep standing to urinate. Further review of th Physician Progress Physician Progress Prostatic Hypertrop clamp catheter and when we can." (sic) Continued review o nursing notes. "7/26 (French) catheter in yellow urine" (sic) The Foley catheter at 2 p.m. Continued review o produce physician to include a Foley of treatment if the Fole clogged and routine On August 11, 2016 10:20 the surveyor Nurse (LPN # 1) the catheter on admiss was discontinued o notified LPN (#1) the failed to produce physician catheter care to Re reviewed the clinical surveyor pointed of summary, physician nursing notes. LPN	age 20 e home meds of foley in due to trouble " (sic) ne clinical record produced a sonote dated 7/27/16. The sonote documented: "Benign only without obstruction Will wean and D/c (discontinue)) of the clinical record produced 8/16 12:10 AM16 f on place and draining dark	TAG		CROSS-REFERENCED TO THE APPROP	de for ON or or eter will be eview, hange stice.
	are not there."	care. LPN (#1) stated, "They S at 11:15 a.m. the survey				

team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Corporate Compliance Nurse

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					0.0938-0391
		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	tX2) MULT	TPLE CON	ISTRUCTION		TE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER	i				MPLETED C
		495371	B WING				3/11/2016
NAME OF F	ROVIDER OR SUPPLIER				FADORESS, CITY, STATE, ZIP COC	ΣE	
					D VIRGINIA AVENUE		
HERITAG	E HALL-RICH CREE	K		RICH	CREEK, VA 24147		
(X4) IO PREFIX TAG	ACA OR OREIGIENCY	TEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI) TAG	·	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCEO TO THE AP OEFICIENCY)	HOULO BE	IX51 COMPLETION OATE
	Team (AT) that Recatheter on admiss facility staff did not and treatment of the On additional information on the facility at the facility must be the facility must b	yor notified the Administrative sident #16 had a Foley sion to the facility and that the obtain orders for routine care see Foley catheter. mation was provided prior to as to why the facility staff failed orders for Foley catheter care		323	F323 Corrective Action(s): Resident #8's attending phy bcen notified that facility sta ensure a physician ordered fa	iff failed to	п
	by: Based on observer record review it was staff failed to ensure accident hazards sample survey, Refor Resident #8, of for falls, the facility physician ordered. The Findings Included but were admitted on 3/12/included but were	who had been identified at risk y stair failed to ensure that a fatt mat was in place.	I		place as ordered. A facility in accident form has been compincident. Identification of Deficient Practices/Corrective Action All other residents with phys fall mats or other preventive prevent falls may have been affected. The DON, ADON a Manager will conduct a 100% all residents with physician comats and fall prevention devidentify residents at risk for in application of the equipment residents identified at risk with corrected at time of discovery lincident & Accident form with completed for each negative attending physician will be negative.	n(s): sician ordered devices to potentially and/or Unit review of ordered fall ices to inconsistent. All ill be y and an finding. The	j

ischemic, hypertension, Parkinson's, coronary

The most current Minimum Data Set (MDS)

artery disease and dementia.

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

each incident.

Facility IO: VA0206

				`	SELUTED AGGREGATE
DEPART	MENT OF HEALTH	AND HUMAN SERVICES		·	PRINTED: 08/25/2016 FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT	OF OFFICIENCIES OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO
710 (0.11)		}	, , , , , , , , , ,		c
		495371	B WING		08/11/2016
NAME OF	PROVIDER OR SUPPLIER	J	· ·	STREET AOORESS, CITY, STATE, ZIP COOE	:
1				120 OLD VIRGINIA AVENUE	
HERITAC	SE HALL-RICH CREE	K		RICH CREEK, VA 24147	
(X4) IO PREFIX TAG	(FACH OFFICIENC)	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG	PROVIOER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROOFICIENCY)	O BE COMPLETION
F 323	Continued From pa	nge 22	F 3	23	
	Quarterly MDS ass Reference Date (Al staff coded that Re Summary Score of that Resident #8 re with Activities of Da J. Health Condition Resident #8 was at also coded that Re- no injury. On August 10, 2016 observed Resident observed a fall mat located to the right	d in the clinical record was a dessment with an Assessment RD) of 6/22/16. The facility sident #8 had a Cognitive 6. The facility staff also coded quired total nursing care (4/3) ally Living (ADL's). In Section s the facility staff coded that trisk for falls. The facility staff sident #8 had had 2 falls-with 6 at 8:05 a.m. the surveyor #8 lying in bed. The surveyor rolled up and placed in a chair of the door entering Resident		Systemic Change(s): The facility policy and procedure for prevention and management has beer eviewed and no revisions are warrar at this time. The DON and/or region nurse consultant will inservice all Licensed Nursing staff regarding prouse of and application of fall prevent equipments to include fall mats and wheelchair and bed alarms to preventalls.	n nted al oper tion
	#8's room. On August 10, 2016 reviewed Resident	6 at 8:30 a.m. the surveyor #8's clinical record. Review of		Monitoring: The DON is responsible for maintain compliance. The DON and/or Unit	ning

reviewed Resident #8's clinical record. the clinical record produced signed physician orders dated 7/29/16. Signed physician orders included, but were not limited to: "Floor fall mate for safety." (sic) The order originated on 6/23/16. Continued review of the clinical record produced the Comprehensive Care Plan (CCP). The surveyor reviewed of the CCP. The CCP identified the following "Problem/Need" and "Approaches." "Problem/Need: 6/24/16 Falls (name of-Resident withheld) is at risk for fall r/t (related to) impaired mobility and judgement at times r/t dementia. Non-compliant with call bell at times, MX (multiple) falls over last qtr (quarter). HX (history) of getting up unassisted from bed/chair. Approaches: Fall ease mat beside bed." (sic)

On August 10, 2016 at 8:35 a.m. the surveyor observed Resident #8 lying in bed. The surveyor once again observed a fall mat rolled up and placed in a chair in Resident #8's room. The surveyor observed a Licensed Practical

and/or practice. Completion Date: 9/2// 6

Manager will perform daily inspections of

all residents with physician order fall prevention devices to monitor for

compliance. Any/all negative findings will be corrected at time of discovery and

disciplinary action will be taken as

needed. Aggregate findings of these

Assurance Committee quarterly for

reviews will be reported to the Quality

review, analysis, and recommendations

for change in facility policy, procedure,

PRINTED: 08/25/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES IX3] DATE SURVEY JX2J MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER. A BUILDING_ AND PLAN OF CORRECTION 08/11/2016 P. WING 495371 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 120 OLD VIRGINIA AVENUE HERITAGE HALL-RICH CREEK RICH CREEK, VA 24147 PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX OATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION! TAG DEFICIENCYL TAG F 323 F 323 Continued From page 23 Nurse (LPN #3) just outside of Resident #8's room. The surveyor notified LPN (#3) that Resident #8 was supposed to have a fall mat at the side of the bed. The surveyor notified LPN (#3) that the fall mat was rolled up and placed in a chair. The surveyor and LPN (#3) walked to Resident #8's room and the surveyor pointed out that the fall mat was rolled up and placed in the chair. LPN (#3) obtained the fall mat and placed the fall mat on the right hand side of the bed. On August 10, 2016 at 3:55 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON), Assistant Director of Nursing (ADON) and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #8 had a history of falls and had a physician order for a fall mat at the side of the bed. The surveyor notified the AT that the fall mat was observed rolled and placed in a chair in the room on two separate occasions. No additional information was provided prior to exiting the facility as to why the facility staff failed to implement physician ordered fall interventions for Resident #8. F 504 F 504 483.75(j)(2)(i) LAB SVCS ONLY WHEN SS=D ORDERED BY PHYSICIAN The facility must provide or obtain laboratory

services only when ordered by the attending

Based on staff interview, facility document review and clinical record review, the facility staff failed to obtain a physician order prior to obtaining laboratory tests for 3 of 23 residents (Resident

physician.

EvenI ID: YT7B11

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

PRINTED: 08/25/2016 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO.	0938-039
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		E SURVEY IPLETEO
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	495371	B WING _		08/	11/2016
NAME OF PROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE		
HERITAGE HALL-RICH CREE	к		120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147		
PREFIX (EACH OFFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPR OEFICIENCY)	ULO BE	1X5) COMPLETION DATE

F 504 Continued From page 24 #7, Resident #17, and Resident #22).

The findings included:

1. The facility staff failed to obtain a physician order prior to obtaining Vancomycin trough levels on Resident #7.

Resident #7's clinical record was reviewed 8/9/16 and 8/10/16. Resident #7 was admitted to the facility 8/21/15 with diagnoses that included but not límited to multiple sclerosis, traumatic amputation at knee level, seizures, heart failure, hypertension, colostomy, depressive disorder, gastroesophageal reflux disease, anemia, and abnormal posture.

Resident #7's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/27/16 assessed the resident with a brief interview for mental status as 14 out of 15.

During clinical record review of the laboratory section, a vancomycin trough level result was found dated 3/22/16.

The surveyor was unable to locate a physician order for the Vancomycin trough level completed 3/22/16. The surveyor requested the director of nursing 's assistance to locate the order. The DON was unable to locate a physician order for the Vancomycin trough level. The surveyor reviewed the laboratory request form dated 3/22/16 provided by the DON. On the laboratory request form dated 3/22/16, in addition to Resident #7's confidential information, was written "v (check) trough." No specific trough level was ordered. A second lab request dated 3/23/16 read to check gentamycin trough.

F 504

F504

Corrective Action(s):

Resident #7's attending physician has been notified that the facility obtained a Vancomycin Trough level test without a physician order. A facility Incident & Accident form has been completed for this incident.

Resident #17's attending physician has been notified that the facility obtained a TSH lab test without a physician order. A facility Incident & Accident form has been completed for this incident

Resident #22's attending physician has been notified that the facility obtained CBC, CMP, Lipid panel, Vitamin D level, HgbA1C and a TSH lab tests without a physician order. A facility Incident & Accident form has been completed for this incident.

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

All other residents may have potentially been affected. A 100% audit of resident clinical records will be completed to identify residents who may have had laboratory tests completed without a physician order. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A Facility Incident & Accident form will be completed for each incident.

PRINTED: 08/25/2016

		AND HOWAN SERVICES			FORM APPROVE
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	,		<u>ОМВ NO. 0938-039</u>
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UEBISA	SELLA LE DIOU OBEE		•	120 OLD VIRGINIA AVENUE	
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F 504	Continued From pa	ge 25	F f	504	
, 50,	· ·	ders for Gentamycin but not	, ,		
	orders for Vancomy			Systemic Changes:	,
	2.22.2.2.73.73.700111 y			The facility policy and procedure been reviewed and no clianges at	e has
		ned the administrator, the		warranted at this time. Licensed	siaff
		the assistant director of		will be inserviced on the policy a	and
		gional registered nurse		procedure for obtaining resident	
		ove finding on 8/10/16 at 3:55		laboratory tests, which includes	
	p.m.			obtaining a physician order prior	to
	No further informati	on was provided prior to the		obtaining the lab test.	
	exit conference on	8/11/16		Monitoring:	
	exit cometence on	5,11,710.		The DON is responsible for mair	ntaining
	2. The facility staff	failed to obtain a physician		compliance. The DON or ADON	
		ing a TSH (thyroid stimulating		review all lab tests results weekly	y to
	hormone) level on F	Resident #17.		ensure that all resident lab tests of	
				liad an appropriate physician ord	
		of Resident #17 was reviewed		the lab tests prior to obtaining. A negative findings will be reported	
		#17 was admitted to the facility		attending physician and the appro	
		tted 8/10/16 with diagnoses t limited to chronic respiratory		disciplinary action taken for staff	
		bined systolic and diastolic		involved. The results of these aud	dits will
		ibrillation, pneumonitis,		be reported to the Quality Assura	
		ryroidism, and obstructive		Committee for review, analysis,	
	sleep apnea.			recommendations for change in f policy, procedure, and/or practice	
	assessment with an (ARD) of 8/4/16 ass	y minimum data set (MDS) assessment reference date essed the resident with a brief status as 15 out of 15.		,	
	reviewed. Laborato were complete blood comprehensive met	on of the clinical record was ry results obtained on 8/4/16 d count (CBC), abolic panel (CMP), nd TSH (thyroid stimulating		Completion Date: 9/	21/16

hormone).

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DEFAIL		MEDICAID SERVICES			•	OMB NO	<u>). 0938-0391</u>
STATEMENT	OF DE FICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL.	E CONSTRUCTION	(X3) DA	TE SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD	ING .			C
		495371	B. WING			0{	3/11/2016
NAME OF	PROVIDER OR SUPPLIER	1700011		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
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T 504	Otimed From pa	on 26	F.	504			
F 504	Continued From pa Mag (magnesium) 8/4/16.	level were ordered to be done					
	The surveyor was used order for the TSH of	unable to locate a physician btained 8/4/16 as well.					
	licensed practical n	riewed the unit manager urse #7 on 8/11/16 at 8:00 the physician orders and able to find an order for the					
	surveyor 8/11/16 at	stered nurse informed the 8:35 a.m. that licensed had forgotten to write the					
	The administrative above finding on 8/	staff was informed of the 11/16 at 12:15 p.m.					
	No further informat exit conference on	ion was provided prior to the 8/11/16.					
	order prior to obtain	failed to obtain a physician ning laboratory tests that were /16 for Resident #22.					
	8/11/16. Resident 6/22/16 with diagnoral limited to type 2 dia cancer, edema, hy hypothyroidism, Ala	of Resident #22 was reviewed #22 was admitted to the facility oses that included but not abetes mellitus, metastatic liver pertension, hyperlipidemia, zheimer's disease, dementia disturbances, dysphagia, and reflux disease.					
	Resident #22's adr set (MDS) assessr	mission (5 day) minimum data ment with an assessment					

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

PRINTED: 08/25/2016 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILOING			(X3) OATE SURVEY COMPLETEO	
495371		495371	B WING			C 08/11/2016	
NAME OF I	PROVIDER OR SUPPLIER	<u> </u>		ŞTRE	EET AOORESS, CITY, STATE, ZIP COOE	•	
}		_		120	OLD VIRGINIA AVENUE		
HERITAGE HALL-RICH CREEK				RIC	H CREEK, VA 24147		
(X4) ID PREFIX TAG	(EACH OFFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING (NFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROF OEFICIENCY)) BE	(X5) COMPLETION DATE
F 504	resident with a cognof 15. The laboratory sect reviewed. On 6/27/included a CBC (co (comprehensive me Vitamin D level, He (thyroid stimulating) The surveyor review physician orders and	nitive summary score of 07 out tion of the clinical record was (16 labs were obtained that implete blood count), CMP etabolic panel), lipid profile, moglobin A1C, and TSH hormone).	F	504			
	The surveyor requemanager licensed pat 10:00 a.m. L.P.N record for the physistated she was una	sted the assistance of the unit bractical nurse #7 on 8/11/16 N. #7 reviewed the clinical cian order for the labs and ble to locate the order then sually takes care of the labs.			·· ·		
F 514 SS=D	the above finding of No further informati exit conference on a 483.75(!)(1) RES RECORDS-COMPLLE The facility must mare resident in accordance of the state of th	ned the administrative staff of n 8/11/16 at 12:15 p.m. on was provided prior to the 8/11/16. ETE/ACCURATE/ACCESSIB aintain clinical records on each nee with accepted professional tices that are complete;	F	514			
<u> </u>	accurately documer systematically organ	nted; readily accessible; and					

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-0391	
STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						С	
		495371	B WING			08/11/2016	
NAME OF	PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
OF DITA	SELIALI DICH CREE		ļ		OLD VIRGINIA AVENUE		
MERITA	SE HALL-RICH CREE	N.	ĺ	RIC	H CREEK, VA 24147		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 514	Continued From pa	age 28	F.5	514			
		tify the resident; a record of the					
	resident's assessm	ents; the plan of care and					
	services provided; t	the results of any					
		ening conducted by the State;					
	and progress notes	i.			F514		
					Corrective Action(s):		
	This REQUIREMEN	NT is not met as evidenced			Resident #3's attending physician has		
	by:				been notified that the facility staff faile to maintain a complete and accurate	G.	
		erview and clinical record			bowel movement record within the		
		staff failed to maintain rate bowel movement records			medical record. A facility incident and		
	in the clinical record	d for 1 of 23 residents			accident form has been completed for	this	
	(Resident #3).	210, 10, 20, 20, 10, 10, 10, 10, 10, 10, 10, 10, 10, 1			incident.		
					Identification of Deficient Practices	&	
	The findings include	ed:			Corrective Action(s):		
	The facility staff fail	ed to document bowel			All other residents may have potential	ly 	
		clinical record for Resident #3.			been affected. A 100% audit of reside	ants all	
	IIIO4cilicinto iii tiic o				medical records for the last 30 days w be conducted by the DON, ADON an	d/or	
	The surveyor review	wed Resident#3's clinical			Medical records to identify residents a	at	
	record on 8/9/16 an	nd 8/10/16. Resident #3 was			risk for incomplete and inaccurate both	wel	
		lity 9/20/13 with diagnoses that			movement documentation. All negative	ve	
		ited to Lewy Body dementia, tive disease of nervous			findings will be clarified and/or corre applicable at time of discovery. A fac	ility	
		sis, osteoarthritis, left and right			Incident & Accident form will be		
	knee contractures,	hypertension, and major			completed for each negative finding.		
	depressive disorder				·		
	Resident #3's signif	icant change in assessment					
		MDS) assessment with an					
		nce date (ARD) of 1/22/16					
	assessed the reside	ent with a cognitive summary					
		5. Bowel and Bladder					
	(Section H) assesse incontinent of bowel	ed the residents as always					
	incontinent of bowe	ranu Diauuei.					

The surveyor reviewed the bowel movement records from June 2016 through August 2016.

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

PRINTED: 08/25/2016 FORM APPROVED OMB NO. 0938-0391

		Y			OND NO. 0936-039
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		495371	B WING	- Annual Control of the Control of t	C 08/11/2016
NAME OF PROVICER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COOF	=
HERITAGE	HALL-RICH CREE	K		120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	
(X4) ID SUMMARY STATEMENT OF OEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETICIN	

F 514 Continued From page 29

From 6/20/16 through 6/24/16 (5 days), there was no documentation in the electronic clinical record of bowel movements for Resident #3. From 7/22/16 through 7/25/16 (4 days), there was no documentation in the clinical record of bowel movements for Resident #3. From 7/28/16 through 8/1/16 (5 days), there was documentation that Resident #3 had bowel movements.

The surveyor informed the unit manager licensed practical nurse #9 of the above concern. The surveyor and the unit manager reviewed the electronic bowel movement record. L.P.N. #9 stated the 24 hour report had a column for bowel movements and she provided the 24 hour reports for the above date range. L.P.N. #9 stated the 24 hour report was not in the clinical record and the bowel movement column was added to the 24 hour report to ensure bowel movements were done.

The surveyor informed the administrative staff of the above finding on 8/11/16 at 12:15 p.m.

No further information was provided prior to the exit conference on 8/11/16.

F 514

Systemic Change(s):

The facility policy and procedure has been reviewed and no changes are warranted at this time. All nursing staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include complete and accurate documentation of bowel movement information in the medical record to the acceptable professional standards and practices.

Monitoring:

The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, ant/or practice.