Our Home, Our Family, Our Life, Too.

Heritage Hall of Tazewell • 121 Ben Bolt Avenue • Tazewell, VA 24651 • (P) 276.988.2515

April 18, 2016

Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233-1463

Mr. Miller,

Attached to this cover letter you will find Heritage Hall – Tazewell's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during the Annual survey.

If I can be of further assistance don't hesitate to contact me at (276) 988-2515.

Sincerely;

Davina Hieatt

Davina Hieatt RN, LNHA
Administrator

Printed: 04/14/2016
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING B. WING	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
[illegible]	[illegible] BEN BOLT AVENUE [illegible], VA [illegible]

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F [illegible]	INITIAL COMMENTS [illegible] Medicare/Medicaid [illegible] survey was conducted 3/22/16 through 3/2[illegible]. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 139 at the time of the survey. The survey sample consisted of 27 current Resident reviews (Residents 1 through 21) and 6 closed record reviews (Residents 22 through 27).			
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This Requirement is not met as evidenced by: Based on staff interview and clinical record	F 155	**F 155 Corrective Action(s):** Resident #14 has had their DDNR form and physician orders reviewed by the attending physician and they have been updated and correctly completed to reflect resident #14's code status. An Incident and Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Social Services Department will review all resident's medical records and contact all responsible parties to verify each resident's code status and advance directives to insure that the proper status has been explained and that written notification has been placed in the medical record. RECEIVED APR 2[illegible] 20[illegible] VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sharon Davina Hiatt RN, LNHA	Administrator	4-18-16

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	490152	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SER TAZEWELL TAZEWELL	324 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Continued From page 1)	F 156		

...review, it was determined that the facility staff failed to have the signed Durable Do Not Resuscitate (DDNR) completely filled out on 1 of 21 residents in the sample survey. (Resident #14)

The findings included:

The facility staff failed to have Resident #14's DDNR to be completely filled out by the physician. Resident #14 was admitted to the facility on 11/3/15 with the following diagnoses of, but not limited to, end stage breast cancer with metastasis of the cancer to the bone, high blood pressure, seizures, chronic pain and Stage IV pressure area. The resident was coded on the quarterly MDS (Minimum Data Set, an assessment tool) with an ARD (Assessment Reference Date) of 2/8/16, which coded the resident as having a BIMS (Brief Interview of Mental Status) of 11 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance by 2 or more staff members for dressing, toileting and personal hygiene.

The chart of Resident #14 was reviewed by the surveyor on 3/23/16 and it was noted to have a Durable Do Not Resuscitate (DDNR) signed by the physician and the resident dated for 11/11/15. In Section 1 on the DDNR dated for 11/11/15 the section was left blank which states the following options for the physician to check: "I further certify (must check 1 or 2):

1. The patient is CAPABLE of making an informed decision about providing withholding, or withdrawing a specific medical treatment course of medical treatment ...

2. The patient is INCAPABLE of making an informed decision about providing withholding, or withdrawing a specific medical treatment or course of medical treatment ... "

Neither one of the above documented choices were marked by the physician but had contained

Systemic Change(s);
The Facility policy and procedure was reviewed and no changes are warranted at this time. The Social Services Director has been inserviced on the proper completion of a DDNR and Advance Directives when required. The Social Services Director will discuss with each future admission their advance directives and resuscitation status upon admission to the facility. Any/all concerns 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 Social Services Director is responsible for maintaining compliance. The Social Services Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation 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:05-06-16

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495132	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	121 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 156				

(Continued From page 2
or, physician's signature on the bottom of the DDNR
The unit manager for Unit 3 was notified of the above findings on 3/23/16 at approximately 8:30 am by the surveyor. The Unit 3 manager stated, "One of the boxes in Section 1 has to be marked by the physician and he didn't mark this one."
On 3/23/16 at 3 pm in the conference room the corporate nurse gave the surveyor a copy of the original DDNR dated for 11/11/15 and Section 1 of this document had been checked by the physician. The surveyor noted that the 1st option in Section 1 had been checked on the copy given by the corporate nurse.
At approximately 4:15 pm on 3/23/16, the administrator, director of nursing and the corporate nurse were notified of the above documented findings.
No further information was provided to the surveyor prior to the exit conference on 3/24/16.

F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
SS=C

The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.

The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the

F 156

F156
Corrective Action(s):
The facility has now prominently displayed the Ombudsman contact information and the correct address for the Virginia Department of Health.

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents may have been potentially affected. The Social Services director will meet with the residents to review their resident rights to include the location and posting of pertinent advocacy and licensure contact information.

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	490182	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	421 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	(Continued From page 4			

items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control

Systemic Change(s):
Facility policy and procedure was reviewed and no changes are warranted at this time. The Social Services Director will discuss Resident's Rights monthly during the Resident Council Meeting and report any/all concerns expressed to the Administrator. The Administrator & Social Services Director will investigate & follow through on all concerns.

Monitoring:
The Social Service Director is responsible for maintaining compliance. The Quality Assurance program has an audit tool for monitoring compliance. The audit tool will be completed monthly by the Social Services director to ensure that all State advocacy groups and other pertinent information is posted in the facility. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation.
Completion Date: 05-06-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495152	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWEL	121 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 4	F 156		

unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This Requirement is not met as evidenced by:
Based on observation and staff interview the facility staff failed to post updated information regarding the ombudsman contact information and failed to post the correct address for the Virginia Department of Health.

The findings included.

On 03/24/16 at approximately 8:20 a.m. the state and local advocacy posting on unit 4 was observed. This posting included an out of date address for the Virginia Department of Health (VDH) and Office of Licensure and Certification (OLC). The area where the local ombudsman contact information should have been located was blank. This poster included a date of 09/2005.

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	495452	W [illegible]	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	21 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 5 on 03/24/16 at approximately 7:30 a.m. the state and local advocacy posting in the front hallway was observed. This posting contained the incorrect name for the ombudsman. This posting was dated 1/2007. The administrator and DON were shown the incorrect postings on 03/24/16 at approximately 7:30 a.m. The administrator stated she would have the postings updated. Later in the day on 03/24/16 the local ombudsman verbalized to the surveyor that the facility had contacted her and asked her to bring updated postings to the facility. No further information regarding the incorrect postings was provided to the survey team prior to the exit conference.	F 156		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This Requirement is not met as evidenced by: Based on observation and staff interview, the facility staff failed to post the results of the most recent life safety code surveys. The findings included.	F 167	F167 **Corrective Action(s):** The placement of the Life Safety Survey Results has been corrected and is accessible to all residents to include those in wheel chairs. This was completed after the survey team's observation was reported. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents may have been affected. The Administrator has been inserviced by the regional nurse consultant regarding the regulation stating that a resident and visitors have the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and that the facility must make the results available for examination in a place readily accessible to residents and visitors and must post a notice of their availability. The Administrator will meet	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495152	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	2 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 6	F 000		

On 03/24/16 at approximately 7:00 a.m. the surveyor observed a small sign posted at the desk in the front lobby that indicated the results of the most recent standard survey and life safety code survey were available at the desk for review.

The surveyor observed a binder at this desk. This binder included the results of the most recent standard survey. It did not include any life safety survey results.

Maintenance employee #1 was asked about the missing life safety code survey results on 03/24/16 at approximately 7:45 a.m.

On 03/24/16 at approximately 8:15 a.m. maintenance employee #1 showed the surveyor a binder that contained the results of the most recent life safety code survey completed on 05/13/15 and the results of a federal comparative life safety code survey conducted at the facility on 06/30/15. Maintenance employee #1 stated he would place the results in the binder in the front lobby today.

The administrative team of the facility was notified of the missing life safety code survey results during a meeting with the survey team on 03/24/16 at approximately 2:15 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
SS=D

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical,

F 309

with the resident council to remind residents that survey results are posted for their review.

Systemic Change(s):
The Facility's Policy and Procedure has been reviewed and no changes are warranted at this time. Administrative staff will be inserviced by the administrator on the regulatory requirement that the most current federal and/or state licensure survey and the most current federal and/or state life safety survey be available and accessible at all times to residents, families and guests.

Monitoring:
The Administrator is responsible for compliance. The administrator will perform weekly audits to ensure that the notice of the survey results location and the current survey results are available for examination. Findings from these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: 05-6-16

F309
Corrective Action(s):
Resident #10's attending physician was notified that the facility failed to ensure the resident received cranberry juice with meals as ordered by the attending physician. A facility Incident and Accident form was completed for this incident.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X4) ID PREFIX TAG	(X5) COMPLETION DATE
	495182		03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	121 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	(Continued From page 7 mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care. This Requirement is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow physician orders for 3 of 27 residents (Resident #10, Resident # 12, and Resident #2). The findings included: 1. The facility staff failed to follow physician dietary orders for Resident #10. Resident #10 did not receive cranberry juice as ordered with meals. The clinical record of Resident #10 was reviewed 3/22/16 and 3/23/16. Resident #10 was admitted to the facility 4/1/15 and readmitted 10/5/15 with diagnoses that included but not limited to urinary retention with chronic indwelling Foley catheter, benign prostate hypertrophy without urinary obstruction, pneumonia, presenile dementia, hypertension, diabetes mellitus type 2, acute respiratory failure, hyperlipidemia, anxiety, depression, and muscle atrophy. Resident #10's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 3/8/16 assessed the resident with a cognitive summary score of 10 out of 15 in Section C Summary Score. The current comprehensive care plan dated 3/16/16 identified the problem of nutrition for Resident #10. Approaches included "Cranberry juice per order." The March 2016 physician orders were reviewed 3/23/16. The orders read in part "Cranberry juice with meals tid (three times a day)." The surveyor observed Resident #10 on 3/23/16 at 8:05 a.m. He was positioned in bed and eating breakfast. Breakfast items on the tray were fried		Resident #12's attending physician was notified that the facility staff failed to administer 1 dose of Culterelle to resident #12 as ordered by the physician. A facility Incident and Accident form was completed for this incident. Residents #2's attending physicians was notified that the facility failed to administer 1 dose of an antibiotic. Macrobid to resident #2 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 been 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 their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record and physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician medication orders & treatment orders. The DON and/or	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	458136	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL-TAZEWELL	21 BEN BOLT AVENUE TAZEWELL, VA 24651

TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 309	(Continued from page 8) eggs, cereal with milk, and toasted bagel. The breakfast items on the tray slip include cranberry juice. Resident #10 stated the only juice he got was tomato. The dietary/meal ticket was reviewed. The ticket showed cranberry juice for all meals. The surveyor interviewed certified nursing assistant #1 on 3/23/16 at 8:00 a.m. She was picking up trays. She was asked to check Resident #10's tray again for cranberry juice. She stated "Resident #10 only got milk and tomato juice." The surveyor discussed the concern with the unit manager licensed practical nurse #2 on 3/23/16 at 9:45 a.m. She stated Resident #10 should be getting the cranberry juice. She stated when he came back from the hospital in October 2015 the order was written. L.P.N. #2 stated he had a Foley and urinary tract infections. L.P.N. #2 stated she had written the order and notified dietary. The surveyor reviewed the departmental notes for 10/8/15 2:43 p.m. The note read in part "New orders: Cranberry juice tid with meals; dietary notified. Signed by L.P.N. #2." The surveyor informed the administrator, the director of nursing, and the regional nurse consultant of the above finding on 3/23/16 at 3:30 p.m. No further information was provided prior to the exit conference on 3/24/16. 2. The facility staff failed to administer medications ordered by the physician for Resident #12. The staff did not administer one dose of Culturelle. The clinical record of Resident #12 was reviewed 3/23/16. Resident #12 was admitted to the facility 11/4/15 with diagnoses that included but not limited to sepsis, pressure ulcers, cerebrovascular disease, cellulitis, anxiety,		Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing, and completing physician ordered medication and treatment orders. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit/review all telephone orders daily to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 05-06-16**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) MULTIPLE CONSTRUCTION	(X4) DATE SURVEY COMPLETED
	495153	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL-TAZEWELL	1 ROSEN BOTTOM LANE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
		F 309		

(Continued from page 9)
autonomic osteomyelitis, acute kidney failure, urinary tract infection, gastrostomy status, and hemiplegia.
Resident #12's submission minimum data set assessment (MDS) with an assessment reference date (ARD) of 11/16/15 assessed the resident with a cognitive summary score of 5 out of 15 in Section C.
A telephone order dated 1/13/16 read "-BMP (basic metabolic panel) q (every) 2 weeks.-Culturelle 1 cap (capsule) via g-tube (gastrostomy) tube bid (twice a day) x 8 wks (weeks) dx (diagnosis) probiotic."
The surveyor reviewed the January 2016, February 2016, and March 2016 electronic medication administration records (eMAR). The January 2016 eMAR had documentation that Resident #12 was administered 36 doses of Culturelle beginning at 8:00 a.m. on 1/14/16. Resident #12 was administered 58 doses in February 2016. Resident #12 was administered 17 doses in March 2016. Resident #12 received 111 doses total. Resident #12 was ordered 8 weeks of Culturelle twice a day. The facility staff failed to administer one dose of Culturelle. Resident #12 should have received a total of 112 doses of Culturelle.
The surveyor requested a printout of the January 2016, February 2016, and March 2016 eMARs. The surveyor reviewed the eMARs with registered nurse #3 on 3/23/16 at 3:10 p.m. She reviewed the eMARs and stated the issue was the entry of the order. She stated the nurses are counting weeks instead of counting the doses to be administered.
The surveyor informed the administrator, the director of nursing, and the regional nurse consultant of the above concern on 3/23/16 at 3:30 p.m. The administrator stated the nurses needed to count the number of doses to be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	[illegible]	A. BUILDING ______ B. WING ______	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	[illegible] BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 10	F 309		

administered in a calendar before entering the order into the computer.
No further information was provided prior to the exit conference on 3/24/16.
3. For Resident #2, the facility staff administered 19 doses of the antibiotic macrobid when the physicians order was for 20 doses.

Resident #2 was admitted to the facility 02/03/09. Diagnoses included, but were not limited to, heart failure, hypertension, stress incontinence, Alzheimer's disease, personality disorder, and depressive disorder.

Section C (cognitive patterns) of the Residents most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/11/16 was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making.

The Residents clinical record included a copy of a physician's telephone order dated 03/04/16 "Start Macrobid 100 mg BID (twice a day) X 10 days Dx (diagnosis) UTI (urinary tract infection)."

A review of the Residents eMAR (electronic medication administration record) indicated that Resident #2 had only received 19 doses of the antibiotic macrobid when they should have received 20 doses.

On 03/23/16 at approximately 3:25 p.m., during a meeting with the survey team, the DON (director of nursing), nurse consultant, and administrator were notified that the facility staff had not administered the correct amount of the antibiotic macrobid.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495164	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER: [illegible]

STREET ADDRESS, CITY, STATE, ZIP CODE: 21 BEN BOLT AVENUE, TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 309 Continued From page 11

F 309 Continued From page 11
additional information regarding this issue was provided to the survey team prior to the exit conference.

F 329 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
SS=D

Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.

Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This Requirement is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to monitor the blood pressure of 1 of 27 residents (Resident #10) after receiving an antihypertensive medication.
The findings included:
1. The facility staff failed to monitor Resident #10's blood pressure after Resident #10 received

F 329

F 329
Corrective Action(s):
Resident #10's attending physician was notified that the facility staff failed to monitor Resident #10's blood pressure 2 hours after the administration of the antihypertensive Clonidine. The licensed staff member involved in the medication pass has received inservice training on the proper administration of medication. A facility Incident & Accident form and a medication error form was completed for this incident.

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents receiving antihypertensive medications may have been potentially affected. The DON, ADON and/or Unit Manager will review the medication orders of all residents receiving antihypertensive medications to ensure proper monitoring of medication affects and required monitoring prior to and after administration is being completed. Any/all negative findings will be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will be completed for each negative finding.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) DATE SURVEY COMPLETED
495182	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	2 BERT BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329				

(X4) ID PREFIX TAG: F 329

(X5) COMPLETION DATE:

(continued from page 12)

and medication Clonidine. The facility shall take to obtain the blood pressure 2 hours after the administration of the antihypertensive medication. The clinical record of Resident #10 was reviewed 3/22/16 and 3/23/16. Resident #10 was admitted to the facility 4/1/15 and readmitted 10/5/15 with diagnoses that included but not limited to: urinary retention with chronic indwelling Foley catheter, benign prostate hypertrophy without urinary obstruction, pneumonia, presenile dementia, hypertension, diabetes mellitus type 2, acute respiratory failure, hyperlipidemia, anxiety, depression, and muscle atrophy.

Resident #10's significant change in assessment minimum data set (MDS) with an assessment reference date (ARD) of 3/8/16 assessed the resident with a cognitive summary score of 10 out of 15 in Section C Summary Score.

Physician order dated 2/28/16 0545 (5:45 a.m.) read "Pyridium 100 mg (milligrams) po (by mouth) tid (three times a day) prn (whenever necessary) for 72 hrs (hours). Clonidine 0.1 mg one x (time) dose d/t (due to) elevated BP (blood pressure). Recheck BP in 2 hrs. Notify oncall if still ? (elevated)."

The surveyor reviewed the February 2016 electronic medication administration record (eMAR). The entry on the 2/28/16 had documentation that Resident #10 received Clonidine 0.1 mg at 7:00 a.m. The surveyor was unable to locate a documented blood pressure 2 hours after the medication was administered on the eMAR.

The surveyor reviewed the 2/28/16 departmental notes for Resident #10. The 2/28/16 departmental note written at 7:37 a.m. read in part "Received order to start Pyridium 100 mg tid x ' s 72 hrs. B/P elevated 201/104 received order to give Clonidine 0.1 mg one x dose recheck B/P in 2 hrs Notify on call if still elevated..."

Systemic Change(s):
The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring of all medications. This includes pre-administration and post administration monitoring and proper assessment prior to administration of medications. This includes the protocol for assessing blood pressures prior to and post administration of antihypertensive medications.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or Unit Manager will complete 2 random medication pass audits weekly to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: 05-06-16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 485134	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAZEWELL HEALTHCARE	21 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	(Continued from page 13) The surveyor reviewed the record for Resident #15 on 2/28/16. The last entry on 2/28/16 at 1:40 p.m. did have a documented blood pressure of 153/80. However, the blood pressure obtained and documented was greater than the 3 hours as ordered by the physician. The surveyor reviewed the electronic vital signs for 2/28/16. There were no recorded vital signs for 2/28/16. The surveyor interviewed the unit manager licensed practical #2 on 3/23/16 at 10:35 a.m. L.P.N. #2 reviewed Resident #10's clinical record for 2/28/16 and stated she couldn't find where the blood pressure had been obtained. The surveyor informed the administrator, the director of nursing, the regional nurse consultant, the chief operating officer and the ombudsman of the above finding on 3/24/16 at 2:15 p.m. No further information was provided prior to the exit conference on 3/24/16.			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This Requirement is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a medication error rate less than 5%. Two medication errors were observed out of 26 opportunities, resulting in a medication error rate of 7.69% and affected 1 of 27 residents (Resident #15). The findings included: The facility staff failed to ensure a medication error rate of less than 5%. There were two medication errors out of 26 opportunities for a	F 332	F332 Corrective Action(s): The Resident #15 involved in Medication Pass Observation has had their attending physicians notified of the medication errors that were committed. LPN #4 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was completed for each medication error. Identification of Deficient Practices & Corrective Actions(s): All residents may have potentially been affected. A 100% medication pass audit of all licensed nurses within the facility will be conducted to identify those nurses	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	46d' 57	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWEL	21 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S [illegible]	(Continued From page 14	F 332		

medication error rate of 7.69% [illegible] Resident #15 was affected.
The surveyor observed a medication pass and tour on 3/23/16 beginning at 7:30 a.m. with licensed practical nurse #4. L.P.N. #4 prepared and administered unsampled resident #1's medication and administered them at 7:36 a.m. L.P.N. #4 prepared Resident #15's medications beginning at 7:36 a.m. The medications were: Norvasc 5 mg (milligrams) tablet, Klor-Con 20 mEq (milliequivalents) tablet, Thera M tablet, Lasix 20 mg (1 tablet), ASA (aspirin) 81 mg EC (enteric coated) tablet, TUMS 300 mg, Carafate 1 gram tablet, and Cranberry concentrate 500 mg capsule.
L.P.N. #4 placed the Norvasc, Klor Con, Thera M, Lasix, TUMS and Carafate in a plastic sleeve and crushed the medications. L.P.N. #4 then placed all of the medications in applesauce. L.P.N. #4 then placed the ASA and the cranberry capsule in the applesauce. L.P.N. #4 stated that the ASA and the Cranberry capsule could not be crushed. L.P.N. #4 then administered the medications to Resident #15 at 7:50 a.m.
L.P.N. #4 crushed the medication Klor Con 20 mEq and administered Lasix 20 mg-not Lasix 60 mg.
During the reconciliation of Resident #15's administered medications with the most recent signed physician orders dated 2/5/16, the orders read as follows: "Klor-Con 20 mEq p.o. (by mouth) qd (every day) dx (diagnosis): hypokalemia. Furosemide (Lasix) 60 mg p.o. qd dx: CHF (congestive heart failure)."

The surveyor interviewed L.P.N. #4 after the medication pass. The surveyor informed L.P.N. #4 of the discrepancies in the medication pass. The surveyor and L.P.N. reviewed the medication labels for both the Klor-Con and Lasix.

at risk for Medication Administration and/or technique errors. A facility Incident & Accident form will be completed for each negative finding as well as one-on-one inservice training and appropriate disciplinary action if warranted for nursing staff observed.

Systemic Change(s):
The facility Policy and Procedure for medication administration has been reviewed and no changes are warranted at this time. All Licensed nursing staff will be inserviced by the DON or ADON on the facility policy and procedure for medication administration. Inservices will include administering medication per physician order and the 5 rights of medication administration and what can and cannot be crushed.

Monitoring:
The Director of Nursing is responsible for maintaining compliance. The DON, ADON and/or designee will conduct two random weekly medication pass observations of licensed nurses to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action will be taken. All discrepancies found in these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date:05-06-16

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	485167	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - TAZEWELL	99 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	F 453			

(Continued From page 15)

Lasix. Lasix label read "Furosemide 20 mg tablet Take 3 tablets (60 mg) by mouth every day (OHF)." The Klor Con label read "Klor-Con M20 20 mEq tab ER (extended release) Take 1 tab by mouth every day DO NOT CRUSH."

[illegible] stated "I might [illegible] the packaging for the Lasix. Usually there are 3 tabs in the package or a 40 mg tablet and a 20 mg tablet. I'll go back and give the other 2 tablets. It's on the label not to crush the potassium. I think it's an insurance thing. I usually have a capsule and the capsule can be opened and sprinkled on the applesauce."

The surveyor informed the administrator, the director of nursing, and the regional nurse consultant of the above finding on 3/23/16 at 3:30 p.m. and requested the facility policy on administering medications and the facility list of DO NOT CRUSH Medications.

The surveyor reviewed the facility policy on Administering Medications on 3/24/16. The policy read in part "3. Medications must be administered in accordance with the orders, including any required time frame." The DO NOT CRUSH list, reviewed 3/24/16, included Klor-Con Tablet SA (sustained release).

Resident #15 was admitted to the facility 4/10/12 with diagnoses that included but not limited to chronic ischemic heart disease, hypertension, hyperlipidemia, and anemia.

Resident #15's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/15/16 assessed the resident with short term memory problems, long

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	495182	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERRY BY-THE-RIVER	2 BEN BOLT AVENUE HAZLETON, VA 20455

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Continued from page 16)	F 332		

memory problems, and moderately impaired cognitive skills for decision making-decisions made.

No further information was provided prior to the exit conference on 3/24/16.

F 514 483.75(l)(1) RES
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This Requirement is not met as evidenced by:
Based on staff interview, facility document review and clinical record review the facility staff failed to ensure a complete and accurate record for 2 of 27 Residents, Resident #4 and Resident #21.

The findings included: For Resident #4 the facility staff incorrectly documented that the medications Celexa and Colace were not administered due to "not in use, Resident in bed". This documentation was related to restraint usage.

Resident #4 was admitted on 03/01/14. Diagnoses included but not limited to hypertension, anxiety, depression, anorexia,

F514
Corrective Action(s):
Resident #4's attending physician has been notified of the inaccuracy with the documentation regarding the administration of resident #4'sColace and Celexa medication. A facility incident and accident form has been completed for this incident.

Resident #14's attending physician has been notified that the facility staff failed to accurately transcribe resident #14's diet order correctly in the medical record. Resident #14's diet has been reviewed and clarified and the dietary department has been made aware of the current diet order. A facility incident and accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All other residents may have potentially been affected. A 100% audit of resident medical records for the last 30 days will be conducted by the DON, ADON and/or Unit Manager to identify residents at risk for inaccurate medication order documentation and inaccurate diet orders. All negative findings will be clarified and/or corrected as applicable at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negative finding.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X3) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496758	A. BUILDING _____ B. WING _____	03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	21 BEN SCOTT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	(Continued from page 17) constipation, gastroesophageal reflux disorder and osteoporosis. The most recent comprehensive MDS (minimum data set) MDS and ARD (assessment reference date) of 12/01/15 coded the Resident as 3 out of 15 in Section C cognitive patterns. Resident #4's medical record was reviewed on 03/23/16. It contained a signed physician's order summary which read in part "Colace 100mg take 2 caps po (by mouth) daily at bedtime" and "Celexa 10mg po QHS (bedtime)". Resident #4's MAR's (medication administration record) for February and March were reviewed on 03/23/15. The MAR's contained entries which read in part "Colace 100mg take 2 caps po daily at bedtime" and "Celexa 10mg po QHS". The February MAR was marked on 02/22/16 and 02/27/16 with "N" for these medications. The March MAR was marked on 03/08/16 with "N" for these medications as well. The detail section of the MAR's contained notes made by the administering nurse (LPN #1) which read in part "11:43PM, 2/22/16 (Scheduled 9:00PM, 2/22/16; Celexa 10mg PO at bedtime DX: Anxiety) Celexa 10mg PO At Bedtime DX: Anxiety scheduled for 02/22/2016 9:00 PM. not in use Resident in bed." and "11:43PM, Colace 100mg take 2 caps po daily at be...scheduled for 02/22/2016 9:00PM. not in use resident in bed.". This was also the entry on the detail section of the MAR for 03/08/16. The surveyor spoke with the administrator on 03/23/16 and asked what "N" stood for and the administrator stated it meant the medication had not been administered. The surveyor spoke with LPN (licensed practical nurse) #1 on 03/23/16 regarding the entries on Resident #4's MAR. LPN		**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant 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 accurate documentation of medical information in the medical record, the Physician Orders, the MAR's, TAR's, ADL records and accurate diet orders according to the acceptable professional standards and practices. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will audit medical records, MAR's, TAR's, ADL 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, and/or practice. **Completion Date: 05-06-16**	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495154	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 03/24/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RICHLANDS HEALTH CARE CENTER	21 BEN BOLT AVENUE RICHLANDS, VA 24641

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX CODE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314				

(Continued from page 18)

It stated that she had inadvertently marked the applications with "5" and made the note when she was recording restraint usage for Resident #2. She also stated that this had happened before and she had corrected it but must have not noticed these entries.

The concern of the surveyor was brought to the attention of the administrative staff during a meeting on 03/23/16 at approximately 1530.

No further information was provided prior to exit.

#2. The facility staff failed to obtain a physician's order to change Resident #14 's diet from a clear liquid diet to a regular diet.
Resident #14 was admitted to the facility on 11/3/15 with the following diagnoses of, but not limited to, end stage breast cancer with metastasis of the cancer to the bone, high blood pressure, seizures, chronic pain and Stage IV pressure area. The resident was coded on the quarterly MDS (Minimum Data Set, an assessment tool) with an ARD (Assessment Reference Date) of 2/8/16, which coded the resident as having a BIMS (Brief Interview of Mental Status) of 11 out of a possible score of 15. Resident #14 was also coded as requiring extensive assistance by 2 or more staff members for dressing, toileting and personal hygiene.
The chart of Resident #14 was reviewed by the surveyor on 3/23/16 and it was noted that a clear liquid diet was ordered on 2/5/16 and timed for 2415 (12:15 am) with a verbal telephone order that had been written that stated, " clear liquid diet d/t (due to) abd (abdominal) distension and constipation per ...(name of physician on call) ... "
In the dietary computer system that was reviewed by the surveyor and the Unit Manager for Unit 3, it was noted that the following order was changed

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495162	A. BUILDING _____ B. WING _____	03/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TAZEWELL HEALTH TAZEWELL	121 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	(Continued From page 19)	F 514		

the computer system dated and timed for 2/5/16 at 1:00 am which stated under order text "Regular". The Unit 3 manager stated that this meant that the clear liquid diet that had been ordered earlier on 2/5/16 at 12:15 am had been changed in the computer system to a regular diet for this resident on 2/5/16 at 1:00 am. Further investigation with the Unit 3 manager and dietary revealed Resident #14 was always given a regular diet and not a clear liquid diet as indicated in the clinical record.

The administrator, director of nursing and corporate nurse were notified of the above documented findings on 3/23/16 at approximately 4:15 in the end of the day conference.

No further information was given to the surveyor prior to the exit conference on 3/24/16