

# Our Home, Our Family, Our Life, Too.

Heritage Hall of Virginia Beach • 5580 Daniel Smith Rd. • Virginia Beach, VA 23462 • (P) 757.499.7029

February 9, 2016

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

Ms. Hudnall;

Attached to this cover letter you will find Heritage Hall – Virginia Beach'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 (757) 499-7029.

Sincerely;



Ashley Jackson  
Administrator

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**HERITAGE HALL**

HEALTHCARE AND REHABILITATION CENTERS

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

PRINTED: 02/02/2016  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/28/2016
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL VIRGINIA BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	
(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 INITIAL COMMENTS

F 000

An unannounced Medicare/Medicaid standard survey was conducted on 1/26/16 through 1/28/16. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow.

The census in this 90 certified bed facility was 86 at the time of the survey. The survey sample consisted of 16 current resident reviews (Residents #1 through 16) and 3 closed record reviews (Residents #17 through 19).

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO  
SS=D PARTICIPATE PLANNING CARE-REVISE CP

F 280

The resident has the right, unless adjudged incompetent or otherwise found to be 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.

F-280

**Corrective Action(s):**

Resident # 11's comprehensive care plan has been reviewed and revised to reflect the non-pharmacological behavior interventions or approaches to be considered and used when indicated instead of or in addition to the administration of PRN Ativan. A Facility Incident & Accident Form was completed for this incident.

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

TITLE

(X6) DATE

*Ms. Ashley B. Jackson, MHA* Administrator 02/09/16

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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This REQUIREMENT is not met as evidenced by:  
Based on staff interview and clinical record review the facility staff failed to revise a care plan for 1 of 19 residents in the survey sample, Resident #11.

The comprehensive plan of care was not revised for Resident #11 to include non-pharmacological behavioral interventions/approaches to be considered and used when indicated, instead of, or in addition to the administration of PRN (as needed) Ativan (an anxiolytic-sedative).

The findings included:

Resident #11 was originally admitted to the facility on 11/6/15 and readmitted on 1/4/16 with diagnoses of a left hip fracture from a fall sustained while at the facility on 12/20/15, Alzheimer's with behavioral disturbance and anxiety.

The current MDS (Minimum Data Set) a significant change with an assessment reference date of 1/11/16 assessed the resident as having long and short term memory deficits. The resident was dependent on the staff for dressing, hygiene and bathing. Resident #11 was resistive to care.

The current psychiatry notes dated 1/19/16 read, in part: "...Staff has reported impulsive combative behavior with physical aggression...PRN IM (an injection) Ativan is in place for stress related anxiety when she is unable to be redirected..."

The current physician orders included; Ativan 2

**Identification of Deficient Practices  
& Corrective Action(s):**

Any/all residents who have behaviors toward acting out, combativeness or resisting care may have potentially been affected. A 100% review of their comprehensive care plans will be conducted by the RCC and/or Social Services director to identify residents at risk. Residents identified at risk will have their behavioral care plan revised at time of discovery to reflect current non-pharmacological interventions to be used when indicated instead or in addition to the use of PRN medication for behaviors. A Facility Incident & Accident Form will be completed for each incident identified.

**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. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant and/or RCC will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition to include changes in resident behaviors.

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F 280	Continued From page 2 mg/ml, take 0.25 ml (milliliter) IM every shift PRN anxiety.  The identified targeted behaviors exhibited by the resident for the use of the Ativan were: screaming, cursing, threatening and combateness during care.  The comprehensive care plan reviewed on 1/27/16 identified as a problem; Impaired cognitive/ communication as evidenced by diagnoses of Alzheimer's Dementia, Mood disorder, anxiety, behavior, history of combateness during care, and history of refusing vital signs (kicking, hitting, refusing meals/med's). The care plan was not revised to include non-pharmacological behavioral interventions/approaches to be considered and used when indicated, instead of, or in addition to the administration of PRN Ativan.  "Behavioral interventions" are individualized non-pharmacological approaches (including direct care & activities) that are provided as part of a supportive physical & psychosocial environment, and are directed toward preventing, relieving, and/or accommodating a resident's distressed behavior.  Review of the electronic medication administration record (MAR) for January 2016 evidenced the resident was medicated 13 times with PRN Ativan 0.25 ml IM (injection) without implementation of non-pharmacological behavioral interventions/approaches. The dates and times are as follows: 1/13 at 1:01 pm, 1/14 at 2:23 am, 1/15 at 3:28 am, 1/15 at 8:56 am, 1/16 at 7:12 am, 1/17 at 3:55 am, 1/18 at 2:41 am and 2:38 pm, 1/19 at 3:01 pm, 1/21 at 4:40 am, and	F 280	<b>Monitoring:</b> The RCC and the IDT will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization to monitor for compliance. 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. <b>Completion Date: February 29, 2016</b>	

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2:04 am, 1/22 at 2:50 am, and 1/27 at 2:45 am.

Review of the clinical record to include nursing notes, daily skilled notes and electronic MARs failed to evidence non-pharmacological behavioral interventions/approaches were implemented prior to or in addition to the use of PRN Ativan on 13 occasions from 1/1/16 through 1/27/16, as listed above.

The Director of Nursing (DON) was interviewed on 1/27/16 at 6:00 pm. The above findings of the failure to revise the resident's care plan to include individualized non-pharmacological behavioral interventions/approaches was shared. The DON stated it was the responsibility of the MDS coordinator to revise care plans. She stated, "I will have her revise it tonight."

F 329 483.25(I) DRUG REGIMEN IS FREE FROM  
SS=E UNNECESSARY DRUGS

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

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**Corrective Action(s):**

Resident #11 has had their current medication regime reviewed for unnecessary drugs and dosage reductions by the attending physician. None are warranted at this time. Resident #11's comprehensive cares plan has been reviewed and revised to reflect the non-pharmacological behavior interventions or approaches to be considered and used when indicated instead of or in addition to the administration of PRN Ativan. A Facility Incident & Accident Form was completed for this incident.

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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 family interview, staff interview, clinical record review and facility document review the facility staff failed to ensure 3 out of 19 residents drug regimen was free from unnecessary drugs, PRN (as needed) Ativan (an anxiolytic), without adequate indications for its use, for Residents #11, #8 and #3.

The facility staff failed to ensure individualized non-pharmacological interventions (such as behavioral interventions) were considered and used when indicated, instead of, or in addition to the administration of PRN Ativan, for Residents #11, #8 and #3.

"Behavioral interventions" are individualized non-pharmacological approaches (including direct care and activities) that are provided as part of a supportive physical and psychosocial environment, and are directed toward preventing, relieving, and/or accommodating a resident's distressed behavior.

The findings included:

1. Resident #11 was originally admitted to the facility on 11/6/15 and readmitted on 1/4/16 with diagnoses of a left hip fracture from a fall

F 329

Resident #3 has had their current medication regime reviewed for unnecessary drugs and dosage reductions by the attending physician. No changes are warranted at this time. Resident #3's comprehensive cares plan has been reviewed and revised to reflect the non-pharmacological behavior interventions or approaches to be considered and used when indicated instead of or in addition to the administration of PRN Ativan. A Facility Incident & Accident Form was completed for this incident.

Resident #8 has had their current medication regime reviewed for unnecessary drugs and dosage reductions by the attending physician. No changes are warranted at this time. Resident #8's comprehensive cares plan has been reviewed and revised to reflect the non-pharmacological behavior interventions or approaches to be considered and used when indicated instead of or in addition to the administration of PRN Ativan. A Facility Incident & Accident Form was completed for this incident.

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sustained while at the facility on 12/20/15,  
Alzheimer's with behavioral disturbance and  
anxiety.

The current MDS (Minimum Data Set) a  
significant change with an assessment reference  
date of 1/11/16 assessed the resident as having  
long and short term memory deficits. The  
resident was dependent on the staff for dressing,  
hygiene and bathing. Resident #11 was resistive  
to care.

Review of the electronic medication  
administration record (MAR) for January 2016  
evidenced the resident was medicated 13 times  
with PRN Ativan 0.25 ml (milliliters) IM (injection)  
without implementation of non-pharmacological  
behavioral interventions/approaches. The dates  
and times are as follows: 1/13 at 1:01 pm, 1/14 at  
2:23 am, 1/15 at 3:28 am, 1/15 at 8:56 am, 1/16  
at 7:12 am, 1/17 at 3:55 am, 1/18 at 2:41 am and  
2:38 pm, 1/19 at 3:01 pm, 1/21 at 4:40 am, and  
2:04 am, 1/22 at 2:50 am, and 1/27 at 2:45 am.

The identified targeted behaviors exhibited by the  
resident for the use of the Ativan were;  
screaming, cursing, threatening and  
combateness during care.

The comprehensive care plan reviewed on  
1/27/16 was not revised to include individualized  
non-pharmacological behavioral  
interventions/approaches to be considered and  
used when indicated, instead of, or in addition to  
the administration of PRN Ativan.

Review of the clinical record to include the  
nursing notes, daily skilled notes and the  
electronic MARs failed to evidence

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**Identification of Deficient Practice(s)  
and Corrective Action(s):**

All residents presently receiving PRN  
antianxiety medication may be potentially  
affected. The facility will conducted a  
100% review of all residents receiving  
PRN antianxiety medication for  
appropriate use of non-pharmacological  
interventions are in use and documented,  
appropriate medical diagnosis to support  
use, and behavior monitoring is being  
done. The attending physicians for all  
residents identified at risk will be  
contacted for appropriate intervention. A  
Facility Incident & Accident form will be  
completed for each negative finding.

**Systemic Change(s):**

The facility policy and procedure has  
been reviewed and no changes are  
warranted at this time. The nursing staff  
will be inserviced by the DON and/or  
psychiatric nurse practitioner on the  
importance of implementing and  
documenting non-pharmacological  
interventions or approaches prior to  
administering PRN antianxiety  
medications. The psychiatric nurse  
practitioner will review all residents on  
antianxiety medications monthly to  
review non-pharmacological approaches  
or interventions in place and revise or  
recommend changes or additions to those  
interventions or approaches as needed.

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non-pharmacological behavioral interventions/approaches were implemented prior to or in addition to the use of PRN Ativan on 13 occasions from 1/1/16 through 1/27/16, as listed above.

The current psychiatry notes dated 1/19/16 read, in part: "...Staff has reported impulsive combative behavior with physical aggression...PRN IM Ativan is in place for stress related anxiety when she is unable to be redirected..."

Review of the current physician orders included the following psychiatric medications:

1. Ativan 2 mg/ml, take 0.25 ml IM every shift PRN anxiety.
2. Celexa 10 mg (milligrams) one tablet every morning for depression.
3. Depakote 250 mg/ 5 ml, take 5 ml by mouth three times a day, for mood.
4. Aricept 5 mg tablet, take one by mouth every night for Dementia.

Licensed practical nurse (LPN #5) was interviewed on 1/27/16 at 5:20 pm. She was asked about Resident #11's behaviors. She stated, "When I come in she is agitated somedays even when you try to just say hello. I notice she becomes more agitated for me in the evening around 7-8 pm. She can be combative, curse at you and scream...she is very hard to redirect...sometimes I leave her alone and come back 10-15 minutes later, sometimes that works..if she is still combative I get another nurse to assist me...if she can't be encouraged I check for pain and administer a pain medication...one of the CNAs (certified nurse aides) resembles one of the resident's daughters and she responds very well with her..." LPN #5 stated

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**Monitoring:**

The DON and/or Unit Manager are responsible for compliance. The Antipsychotic Drug review will be completed monthly to monitor for compliance. The results of these audits will be forwarded to the Quality Assurance Committee monthly/prn for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

**Completion Date: February 29, 2016**

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non-pharmacological interventions are documented on the MAR or nurses notes when used.

A family interview was conducted with two of Resident #11's daughters on 1/28/16 from 11:45 am to 12:30 pm. One daughter was in the room and the other was on speaker phone. Both stated the resident's routine at home was to stay awake late and wake up as late as 2:00 pm. They had expressed this to the facility to help reduce the resident's behaviors. She also stated the resident was in constant pain due to a history of neck surgery and shoulder pain, and this may be why she is combative during care. The daughters both stated the resident was combative at home also and had been taken care of by their brother. The resident was noted to be asleep, in bed on her right side. The resident was still wearing a gown from the night before. A basin was on the bedside table filled with water for the CNA to provide morning ADL care (activities of daily living, a bath).

The failure to implement individualized non-pharmacological interventions/ approaches prior to the use of the PRN Ativan on multiple occasions for Resident #11 was shared with the Administrator and the Director of Nursing at the pre-exit meeting conducted on 1/28/16.

2. The facility staff failed to ensure non-pharmacological approaches were implemented prior to the administration of as

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needed (PRN) antianxiety medications for  
Resident #3.

Resident #3 was admitted to the nursing facility  
on 7/25/14 with diagnoses that included  
behavioral disturbances and anxiety disorder.

The Minimum Data Set (MDS) assessment dated  
10/20/15 coded Resident #3 with short and long  
term memory problems and moderately impaired  
in the skills needed for daily decision making. The  
resident was coded with an anxiety disorder and  
received antianxiety medication.

The care plan dated 11/19/14 and revised on  
12/15/15 identified the resident had anxiety and  
agitation. The goal the staff set for the resident  
was that the staff would anticipate and meet her  
needs daily and PRN. Some of the approaches  
the staff would implement to accomplish this goal  
included approach the resident warmly and  
positively, communicate with the resident in a  
quiet environment, re-direct as needed and give  
medications as ordered-monitor for  
effectiveness/side effects.

Resident #3 had the following physician orders for  
PRN antianxiety medication:

-1/9/16 \*Ativan 0.25 milligrams (mg), 1 tablet by  
mouth (PO) every (Q) 6 hours PRN for anxiety.  
-1/19/16 Ativan 0.5 mg Intramuscular (IM) Q 8  
hours PRN for anxiety.

\*Ativan/Lorazepam is used to relieve anxiety.  
Lorazepam is in a class of medications called  
benzodiazepines. It works by slowing activity in  
the brain to allow for relaxation  
([www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html](http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html)).

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495234</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>01/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>HERITAGE HALL VIRGINIA BEACH</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>5580 DANIEL SMITH ROAD</b> <b>VIRGINIA BEACH, VA 23462</b>	
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Review of the clinical record revealed Resident #3 received PRN Ativan 0.25 mg PO medication 5 times in the month of January 2016 with no supporting documentation to indicate non-pharmacological measures were implemented prior to administering medication.

The most recent Psychiatric Nurse Practitioner notes dated 1/19/16 indicated that the staff was reporting loud screaming when agitated. The plan was for the staff to monitor behaviors for safety concerns and redirect as needed. Give IM Ativan for severe agitation if refusal of the PO Ativan. The notes also indicated the resident was on scheduled Ativan.

Resident #3 was observed 1/26/16 at 3:00 p.m. in her wheelchair. Her eyes were closed, she did not initiate conversation and responded to questions with one or two words. The resident was also observed on 1/27/16 at 10:00 a.m., 12:00 p.m. and 2:00 p.m. up in her wheelchair. Her demeanor remained unchanged. She was observed on 1/28/16 at 11:00 a.m. as a passive participant in an activity. Certified Nursing Assistant (CNA) #2 stated the resident had screaming episodes that required the nurse to intervene and administered medication to stop the screaming.

On 1/28/16 at 11:25 a.m., Licensed Practical Nurse (LPN) #1 stated she was assigned to Resident #3 and all nursing staff to include the CNAs, give food, juice, talk to Resident #3, give magazines, call activity department to involve her in an activity before they give PRN Ativan, but they fail to consistently document their interventions. The effectiveness of the Ativan,

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after it was administered, was documented for each of the 5 times the medication was given, but not what was implemented before pharmacological intervention.

On 1/28/16 at 4:20 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated she did expect the staff to try other measures prior to giving PRN antianxiety medication, but she did not have an avenue by which the nurses could document what they do prior to giving PRN antianxiety medication and she doubted if there was documentation in the nurses notes to support offering and trying non-pharmacological interventions prior to giving medication. They stated they addressed resident behaviors, other interventions and psychotropic medication usage during the Risk Management Committee Minutes. Resident #3 was addressed in the meeting dated 1/15/16. The minutes addressed medication usage only and indicated, "Increase yelling and hallucinations, currently receives Ativan routine and PRN. Psych to follow-up." They stated inservicing took place to address and specifically train the staff on non-pharmacological interventions prior to administering PRN medications to include antianxiety medications. The training was reviewed dated 2/4/15, 6/15/15 and 9/21/15 which did not address non-pharmacological approaches to behaviors prior to PRN medication regimen.

The facility's policy entitled Psychotropic drugs (undated) did not address non-pharmacological interventions/approaches prior to administering PRN antianxiety medications.

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3. The facility staff failed to ensure non-pharmacological approaches were implemented prior to the administration of as needed (PRN) antianxiety medications for Resident #8.

Resident #8 was admitted to the nursing facility on 12/9/15 with diagnoses that included dementia and anxiety disorder.

The Minimum Data Set (MDS) assessment dated 1/10/16 coded Resident #8 with short and long term memory problems and moderately impaired in the skills needed for daily decision making. The resident was coded with an anxiety disorder and received antianxiety medication.

The current care plan dated January 2016 originally dated 11/1/13 identified the resident had anxiety with panic attacks, agitation and a short attention span. The goal the staff set for the resident was that the staff would anticipate and meet her needs daily and PRN. Some of the approaches the staff would implement to accomplish this goal included approach the resident warmly and positively, communicate with the resident in a quiet environment, re-direct as needed and give medications as ordered-monitor for effectiveness/side effects.

Resident #8 had the following physician orders for PRN antianxiety medication:

- 12/9/15 \*Ativan 0.5 milligrams (mg) 1 tablet by mouth (PO) three times a day (TID) PRN for anxiety.
- 1/9/16 Ativan 0.5 mg PO every 8 hours PRN for anxiety.
- 1/5/16 \*Klonopin 0.5 mg PO twice a day (BID) PRN for Ativan.

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\*Ativan/Lorazepam is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation ([www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html](http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html)).

\*Klonopin/Clonazepam is used alone or in combination with other medications to control certain types of seizures. It is also used to relieve panic attacks (sudden, unexpected attacks of extreme fear and worry about these attacks). Clonazepam is in a class of medications called benzodiazepines. It works by decreasing abnormal electrical activity in the brain ([www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html](http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682279.html)).

Review of the clinical record revealed Resident #8 received PRN Ativan 0.5 mg PO medication 11 times from December 2015 to current review date in the month of January 28, 2016, and PRN Klonopin 0.5 mg PO 2 times in the month of January 2016 with no supporting documentation to indicate non-pharmacological measures were implemented prior to administering medication.

The most recent Psychiatric Nurse Practitioner notes dated 1/8/16 indicated that the staff was reported continued anxiety, agitation and verbal outburst with the use of profanity. The plan was for the staff to monitor behaviors for safety concerns and redirect as needed. Discontinue the Klonopin and continue the Ativan PRN for anxiety. The notes also indicated the resident was on scheduled Buspar 15 mg PO BID for anxiety.

Resident #8 was observed 1/27/16 at 12:30 p.m.

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in the restorative dining room sitting in her wheelchair. She was away from the table and the staff said she said she was finished, pushed her food away and backed up from the table. The resident was alert and communicated well, but said in a very loud voice, "I am not interested in what they are getting ready to do over there (referring to the other residents at the table finishing the lunch meal)." The CNAs at the restorative dining room table assisting other residents said they just let the resident do her thing because she could be hard to get along with when she gets irritated and the nurse would have to give her medication to calm her down.

On 1/28/16 at 11:25 a.m., Licensed Practical Nurse (LPN) #1 stated she was assigned as Resident #8's nurse and all nursing staff to include the CNAs, give food, juice, talk to Resident #3, give magazines, call activity department to involve her in an activity before they give PRN Ativan, but they fail to consistently document their interventions. The effectiveness of the Ativan, after it was administered, was documented for each of the 11 times the medication was given, but not what was implemented before pharmacological intervention. The effectiveness of the Klonopin, after it was administered, was documented for each of the 2 times the medication was given, but not what was implemented before pharmacological intervention.

On 1/28/16 at 4:20 p.m., an interview was conducted with the Administrator and the Director of Nursing (DON). The DON stated she did expect the staff to try other measures prior to giving PRN antianxiety medication, but she did not have an avenue by which the nurses could

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document what they do prior to giving PRN antianxiety medication and she doubted if there was documentation in the nurses notes to support offering and trying non-pharmacological interventions prior to giving medication. They stated they addressed resident behaviors, other interventions and psychotropic medication usage during the Risk Management Committee Minutes. Resident #8 was addressed in the meetings dated 11/30/15, 12/21/15 and 1/15/16. The minutes addressed medication usage only and indicated, "Still having panic attacks, still needs Ativan. They stated inservicing took place to address and specifically train the staff on non-pharmacological interventions prior to administering PRN medications to include antianxiety medications. The training was reviewed dated 2/4/15, 6/15/15 and 9/21/15 which did not address non-pharmacological approaches to behaviors prior to PRN medication regimen.

F 332 483.25(m)(1) FREE OF MEDICATION ERROR  
SS=D RATES OF 5% OR MORE

F 332

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 a medication pour and pass observation, staff interview, facility document review and clinical record review the facility staff failed to ensure they were free of medication error rates less than 5%. There were 25 observed medication opportunities with 3 errors, resulting in a 12% medication error rate. The residents involved in the medication errors were Residents

F332

**Corrective Action(s):**

The Residents involved in Medication Pass Observation #7 & #13 have had their attending physicians notified of the medication errors. LPN #2 involved in the medication pass observation has received disciplinary action and a 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.

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#7 (Ferrous Sulfate) and Resident #13  
(Pentoxifylline and Preservision Areds).

The findings include:

1. On 1/26/16 at 5:00 p.m., Licensed Practical Nurse (LPN) #2 administered the incorrect dosage of Ferrous Sulfate to Resident #7. The resident had current physician's orders dated January 2016 for \*Ferrous Sulfate 220 milligrams (mg)/5 ml, give 300 mg (6.8 milliliters) via feeding tube twice a day (BID). LPN #2 poured Ferrous Sulfate into a 30 ml clear plastic medication cup, up to the 7.5 ml graduated mark. The LPN stated, "It is so hard to measure this medication because there is no 6.8 markings, so I go up close to the 7.0 ml mark. Closer inspection of the 30 ml medication cup revealed a 7.5 ml mark and no 7.0 ml mark, thus an error in administration of the medication.

\*Ferrous sulfate provides the iron needed by the body to produce red blood cells. It is used to treat or prevent iron-deficiency anemia, a condition that occurs when the body has too few red blood cells because of pregnancy, poor diet, excess bleeding, or other medical problems (<https://www.nlm.nih.gov/medlineplus/druginfo/me ds/a682778.html>).

Resident #7 was admitted to the nursing facility on 11/16/10 with diagnoses that included anemia.

The resident's care plan dated 9/16/13 identified the resident had a history of anemia and was at risk for increased weakness and low hemoglobin and hematocrit. The goal set by the staff for the resident was that she would be free of

F 332

**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 has been conducted to identify those nurses at risk for Medication Administration and/or technique errors. A facility Incident & Accident form has been 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 and has been reviewed and no changes are warranted at this time. All Licensed nursing staff will be inserviced by the DON and/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.

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complications associated with anemia. Some of the approaches the staff would use to accomplish this goal included to administer the Ferrous Sulfate medication as ordered by the physician.

The Minimum Data Set (MDS) assessment dated 12/4/15 coded Resident #7 11/12/15 was an admission and coded Resident #8 with short and long term memory and moderately impaired in the skills needed for daily decision making. The resident was coded with a anemia diagnosis.

On 1/28/16 at 4:20 p.m., the Administrator and the Director of Nursing (DON) were made aware of the aforementioned observations regarding medication pass errors. The DON stated the LPN should have used a graduated syringe for accuracy and she would be filling out a medication error report.

The facility's policy and procedures entitled Administering Medications dated 12/2012 indicated medications should be administered in accordance with physician's orders and a wrong dosage was an example of a medication error.

2. On 1/26/16 at 4:00 p.m., Licensed Practical Nurse (LPN) #2 administered two medications to Resident #13 that were ordered (January 2016) to be given by mouth with meals, \*Pentoxifylline ER 400 milligrams (mg), 1 tablet by mouth (PO) three times a day (TID) with meals; \*Preservision Areds 2 tablets 250-2.5 mg, 1 tablet PO BID with meals. There was no food at the bedside. It was later observed the resident was served the dinner meal at 5:51 p.m.

\*Pentoxifylline ER This medication is used to

**Monitoring:**

The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will conduct two random weekly medication pass observations of licensed nurses to monitor for compliance. The pharmacy consultant will conduct two medication pass observations of licensed nursing staff during the facility visit. Any negatives 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.

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improve the symptoms of a certain blood flow problem in the legs/arms (intermittent claudication due to occlusive artery disease). Take this medication by mouth with food, usually 3 times daily or as directed by your doctor (<http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archived=6084>).

\*Preservision Areds is eye vitamins specific targeted to (Age Related Macular degeneration) AMD. Directions: Take one Soft Gel twice a day with a full glass of water during a meal(<http://www.preservision.com/products/preservision-areds-lutein-formula>).

Resident #13 was admitted to the nursing facility on 8/12/15 with diagnoses that included Peripheral Vascular Disease (PVD, neuropathy and Macular Degeneration.

The resident's care plan dated 11/04/15 identified the resident had alteration in arterial blood flow and eye problems to include cataracts and macular degeneration. The goal set by the staff for the resident was that he would be free of complications related to these conditions. Some of the approaches the staff was going to implement to accomplish this goal included administer medications as ordered by the physician.

The Minimum Data Set (MDS) assessment dated 11/20/15 coded Resident #13 with a score of 15 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was cognitively intact in the skills for daily decision making.

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On 1/28/16 at 4:20 p.m., the Administrator and the Director of Nursing (DON) were made aware of the aforementioned observations regarding medication pass errors. The DON stated she expected medications ordered to be administered with meals be given to the resident within 20-30 minutes before or after meals.

The facility's policy and procedures entitled Administering Medications dated 12/2012 indicated medications should be administered in accordance with physician's orders and a medications must be administered within one hour of their prescribed time, unless otherwise specified (for example, before and after meal orders).

F 441 483.65 INFECTION CONTROL, PREVENT  
SS=F SPREAD, LINENS

F 441

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program  
The facility must establish an Infection Control Program under which it -  
(1) Investigates, controls, and prevents infections in the facility;  
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and  
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection  
(1) When the Infection Control Program determines that a resident needs isolation to

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**Corrective Action(s):**

The medical director was notified that the facility failed to implement a comprehensive infection control program and failed to accurately complete infection control tracking logs. A facility Incident & Accident form has been completed for each of these incidents.

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prevent the spread of infection, the facility must isolate the resident.  
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:  
Based on staff interview and facility document review the facility failed to maintain an effective Infection Prevention and Control Program in order to prevent, recognize and control, to the extent possible, the onset and spread of infection within the facility.

The facilities Infection Control Program (ICP) failed to include recognition and surveillance designed to optimize the treatment of Urinary Tract Infections (UTI's) while reducing the adverse events associated with antibiotic use.

The Facility Level Quality Measure Report Period from 7/1/15 through 12/31/15 evidenced the facility measure was flagged at 92% with the Comparison Group National Percentile.

The ICP failed to recognize/ track the type of

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**Identification of Deficient Practice(s)  
and Corrective Action(s):**

All other residents may have potentially been affected. A 100% review of all residents with infections will be conducted to identify whether the infection was a community acquired or a nosocomial infection. All identified infections will be listed on the infection control tracking logs to monitor for trends, improvement, last culture and to prevent and control the development of nosocomial infections in the facility. Any/all negative findings related to infection control tracking and trending will be corrected at time of discovery and a facility Incident & Accident form will be completed.

**Systemic Change(s):**

The facility Infection Control policy and procedure has been reviewed and no changes are warranted at this time. The DON, ADON and Unit Managers will be inserviced by the Regional Nurse Consultant on the facility's infection control tracking logs for maintaining proper infection control standards and prevention or facility acquired infections. All staff will be inserviced by the DON and/or Regional Nurse Consultant on the infection Control Policy standard for hand washing to prevent the spread or infections.

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495234	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 01/28/2016
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL VIRGINIA BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	
(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)
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pathogens associated with the facility acquired  
Urinary Tract Infections to ensure  
appropriateness of antibiotic use, that is within  
their control, and failed to meet current CDC  
recommendations/ guidelines for Long Term Care  
Centers to reduce the threat of antibiotic  
resistance.

The findings included:

The Infection Control Program interview was  
conducted with the Director of Nursing (DON) on  
1/28/16 at approximately 2:45 pm. The DON was  
designated as the facilities Infection Control  
Nurse who was responsible for ensuring  
surveillance of facility infections was conducted.  
The DON provided the surveyor with a  
surveillance log for the months of October,  
November and December 2015. The Infection  
Control Tracking System log included the  
residents name, station and room number,  
pathogen/infection type, antibiotic, date of last  
culture, physician order, Minimum Data Set/ Care  
Plan revision and date of next review boxes to be  
filled in.

Review of these surveillance logs for the months  
of October, November and December 2015  
evidenced there were 23 facility acquired UTI's.  
Each of these UTI's were treated with a broad  
spectrum antibiotic.

Further review evidenced there was no  
documentation of the facility acquired UTI's  
pathogen except for three residents who acquired  
ESBL in October 2015.

Extended-Spectrum Beta-lactamase (ESBL) are  
chemicals which are produced by a certain type

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**Monitoring:**

The DON is responsible for maintaining  
compliance. The facility has an infection  
control tracking log for monitoring and  
tracking infections to maintain  
compliance. The DON, ADON and/or  
Unit Manager will complete the infection  
control tracking log weekly and  
review/report all findings to the Risk  
Management Committee for review and  
recommendations. Aggregate findings of  
the reports will be submitted to the  
Quality Assurance Committee quarterly  
for review, analysis, and  
recommendations for change in the  
facility policy and procedure.

**Compliance Date: February 29, 2016**

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of bacteria. The bacteria break down antibiotics, thereby making infections very hard to treat. Most people are infected by the bacteria in hospitals, and this is due improper handing by medical staff. The bacteria can enter the body through the mouth, the urinary tract and any open wounds. It is possible for someone to carry these germs without being affected. Such a person is said to have been colonized by the bacteria. A colonized individual can pass the infection to other people even if he or she is not affected. The infections caused by these bacteria need to be treated with a matter of urgency since they can become fatal.

The first resident was identified on 10/4/15 in room 231 B, the second resident was identified on 10/8/15 in room 230 B and the third resident was identified on 10/15/15 in room 225 B, all rooms were on unit 200.

During the Infection Control Program interview with the DON she stated infections are discussed during the quarterly Medical QA (quality assurance meetings). The DON provided the last quarterly QA topic sheet that was dated October 2015.

The QA topic sheet listed the aforementioned three ESBL UTI's. Written inside the follow up box for the three ESBL infections was, "not on same hall or even unit."

The three resident's were all residing on the same unit; unit 200 (231 B, 230 B and 225 B) when first identified with acquired ESBL infections. An opportunity for effective surveillance of these occurrences was missed.

"Surveillance" refers to the ongoing, systematic

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collection, analysis, interpretation, and dissemination of data to identify infections and infection risks, to try to reduce morbidity and mortality and to improve resident health status.

Further review of the ICP evidenced a failure to identify UTI pathogens to ensure appropriate treatment to reduce the threat of antibiotic resistance.

Nine of the twenty-three UTI's were treated with the anti-infective Nitrofurantoin (Macrobid). This drug is on the Beers Criteria list for Potentially Inappropriate Medication Use in Older Adults. This is a guideline for healthcare professionals to help improve the safety of prescribing medications for older adults. Nitrofurantoin increases the risk for pulmonary toxicity, safer alternatives are available; it is strongly recommended not to be used in the elderly population.

During the interview with the DON, she was asked if there was a tracking system to recognize the type of pathogens associated with the facility acquired Urinary Tract Infections to include appropriate antibiotic use. She stated, "No, but I look up the organism when the cultures come back".

When asked if each of the residents who were treated for a UTI during the last quarter had presented with symptoms of a UTI (to improve antibiotic practices and reduce inappropriate use for asymptomatic bacteriuria), she stated she did not have that information. She stated she would have to research it in each resident's clinical record. The DON stated she is not involved in the decision of what antibiotic the prescriber

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chooses. The DON could not provide evidence of  
monitoring appropriateness of antibiotic use  
related to infection control.

According to the National Health Institute (NIH)  
for Optimal Management of Urinary Tract  
Infections in Older People read, in part: Too often,  
the diagnosis of UTI is made in the absence of a  
typical history and signs resulting in over  
diagnosis and over treatment...The increasing  
prevalence of health care associated infection  
such as Clostridium difficile and emerging  
antibiotic resistance highlights the importance of  
obtaining a firm diagnosis, treating with  
appropriate antibiotics and avoiding the use of  
broad spectrum antibiotics.

Review of the current recommendations from the  
CDC (Centers for Disease Control and  
Prevention) for Antibiotic Stewardship for Nursing  
Homes 2015 read, in part: CDC recommends that  
all nursing homes take steps to improve  
prescribing practices to reduce inappropriate use.  
Antibiotics are among the most frequently  
prescribed medications in nursing homes, with up  
to 70% of residents in a nursing home receiving  
one or more courses of systemic  
antibiotics...40-75% of antibiotics prescribed in  
nursing homes may be unnecessary or  
inappropriate. Harms from antibiotic overuse are  
significant for the frail and older adults receiving  
care in nursing homes.

The CDC also recommends tracking and  
reporting antibiotic use and outcomes related to  
antibiotics in order to guide practice changes and  
track the impact of new interventions.

A copy of the facilities policy and procedure for

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the Infection Control Program was requested.  
The DON provided a copy of a policy. This policy  
did not address Infection Control Program  
Surveillance.  
  
No additional information was provided to the  
survey team prior to exit.

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F 000 Initial Comments

F 000

An unannounced biennial State Licensure Inspection was conducted 1/26/16 through 1/28/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.

The census in this 90 bed facility was 86 at the time of the survey. The survey sample consisted of 16 current resident reviews (Residents #1 through 16), and 3 closed records (Residents #17-19).

F 001 Non Compliance

F 001

The facility was out of compliance with the following state licensure requirements:

This RULE: is not met as evidenced by:  
The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:

12 VAC 5-371-220. Nursing Services  
B and D. Cross reference to F329 and F332.

12 VAC 5-371-250 F. Resident Assessment and Care Planning  
Cross Reference F 280

12 VAC-5-371-220 A. Nursing Services  
Cross Reference F 329

12 VAC-5-371-180 A. Infection Control  
Cross Reference F 441

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

TITLE

(X6) DATE

Mrs. Shuley B. Jackson, LHA

Administrator  
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If continuation sheet 1 of 1