Our Family Exists To Care For Yours.

Heritage Hall of Lexington • 205 Houston Street • Lexington, VA 24450 • (P) 540.464.8181 • (F) 540.464.8184

December 15, 2016

Center for Quality Health Services & Consumer Protection
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Paul Wade, Long Term Care Supervisor
Richmond, VA 23233-1463

Dear Mr. Wade;

Attached to this cover letter you will find Heritage Hall – Lexington'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 (540) 464-8181.

Sincerely;

Matthew DeLong
Administrator

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(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) COMPLETE DATE
F 000	Initial Comments An unannounced biennial State Licensure Inspection survey was conducted 12/06/16 through 12/07/16. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. One complaint was investigated during the survey. The census in this 60 bed facility was 56 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Residents 1 through 12 and 15) and two closed record reviews. (Residents 13 through 14).	F 000	RECEIVED DEC 19 2016 VDH/OLC	
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: Cross Reference to F-Tag 309 12 VAC 5-371-220 (B)	F 001	**F001** **12 VAC 5-371-220 (B)** **Cross reference to F-Tag 309** Cross Reference to POC for F-Tag 309 **Completion Date: 01/13/2017**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Matt DeLong LNHA | ADMINISTRATOR | 12-15-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(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 An unannounced Medicare/Medicaid standard survey was conducted 12/06/16 through 12/07/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of 13 current Resident reviews (Resident # 1 through 12 and Resident # 15) and two closed record reviews (Residents # 13 through 14).	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309	**F309** **Corrective Action(s):** Resident #11's attending physician was notified that the facility staff failed to administer Latanoprost eye drops 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature] LNHA	ADMINISTRATOR	12.15.16

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(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 1 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on medication pass observation, staff interview and clinical record review, the facility staff failed to follow physician's orders for one of 15 residents in the survey sample, Resident #11. Resident received Latanoprost eye drops at the wrong time of day. Findings include: Resident #11 was admitted to the facility on 10/10/2005 with diagnoses including, but not limited to: Glaucoma (elevated pressure within the eye). The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 10/5/16. Resident #11 was assessed as being severely cognitively impaired with a cognitive score of 7 out of 15. During medication pass observation conducted on 12/7/16 at 7:45 a.m. Resident #11 was observed receiving Latanoprost eye drops (one drop to each eye). The label was then reviewed by the surveyor and was noted to read, Latanoprost 0.005% one drop into both eyes at bedtime. This surveyor immediately asked the nurse giving the medication (identified as license practical nurse, LPN #1), if this medication was supposed to be given at this time. LPN #1 reviewed the	F 309	Systemic Change(s): The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and completing physician orders, medication orders, treatment orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as performing physician ordered monitoring and follow up per physician orders. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, and/or ADON will perform weekly chart audits coinciding with the care plan calendar 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: 01/13/2017**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(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 2 label and reviewed Resident #11's medication administration record and verbalized that she (LPN #1) had pulled and gave the wrong eye drops. At this time LPN #1 notified the physician Review of Resident #11's physician's orders also documented "Latanoprost 0.005% Eye drops instill 1 drop both eyes at bedtime" diagnosis, Glaucoma. On 12/7/16 at 1:00 p.m. the above finding was brought to the attention of the administrator and director of nursing. No other information was provided prior to exit on 12/7/16.	F 309		