PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9 to 2 management of	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495152	B. WING		05/24/2018
	PROVIDER OR SUPPLIER GE HALL TAZEWELL		1	TREET ADDRESS, CITY, STATE, ZIP CODE 21 BEN BOLT AVENUE AZEWELL, VA 24651	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
E 000	Initial Comments		E 000		
F 000	survey was conduct 05/24/18. The facil compliance with 42 Requirements for I	Emergency Preparedness cted 05/22/18 through ity was in substantial 2 CFR Part 483.73, Long-Term Care Facilities.	F 000		ii II
	survey was conducted 05/24/18. Correct compliance with 43	Medicare/Medicaid standard cted 05/22/18 through ions are required for 2 CFR Part 483 Federal Long ments. The Life Safety Code ollow.			s. s.
	136 at the time of consisted of 28 ct closed record revision Request/Refuse/D CFR(s): 483.10(c)	scntnue Trmnt;FormIte Adv Dir	F 578	Residents #106 has had their DI reviewed by the DON and the a	ttending ed and
	discontinue treatm	nent, to participate in or refuse sperimental research, and to	1	correctly completed to reflect re #106's code status. An Incident Accident form was completed f incident.	esident : and
	the provision of m	hing in this paragraph should be right of the resident to receive edical treatment or medical medically unnecessary or		Identification of Deficient Pra Corrective Action(s): All other residents may have be potentially affected. The Admi Director and/or Social Services will review all resident's media	een Sission
	requirements spe subpart I (Advand (i) These requirer inform and provid	ne facility must comply with the cified in 42 CFR part 489, se Directives). nents include provisions to e written information to all adult		to ensure the DDNR is accurated out. Any negative findings with the Admission Director and/or Services Director to contact all responsible parties to verify earesident's code status and advitorable.	ely filled the result in Social Clark

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.

Facility ID: VA0117

administrator

PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	25 5		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495152	B. WING			0	5/24/2018
	PROVIDER OR SUPPLIER SE HALL TAZEWELL			121	EET ADDRESS, CITY, STATE, ZIP CODE BEN BOLT AVENUE EWELL, VA 24651		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	500	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 578	medical or surgical resident's option, for (ii) This includes a facility's policies to and applicable Star (iii) Facilities are presentities to furnish the legally responsible requirements of this (iv) If an adult individual information or articular and an articular and give advance individual's resident with State Law. (v) The facility is not provide this information to appropriate time. This REQUIREME by: Based on staff intereview, the facility Durable Do Not Recomplete for 1 of 3. The facility staff fa Department of Heiresuscitate Order accurate for Resident includes a staff in the resuscitate Order accurate for Resident includes a staff in the resuscitate Order accurate for Resident includes a staff in the resuscitate Order accurate for Resident includes a staff in the resuscitate Order accurate for Resident in the resident in	Ing the right to accept or refuse treatment and, at the ormulate an advance directive, written description of the implement advance directives te law. From the description of the implement advance directives te law. From the description but are still for ensuring that the section are met. Fridual is incapacitated at the and is unable to receive sulate whether or not he or she dvance directive, the facility directive information to the at representative in accordance of relieved of its obligation to ation to the individual once he ceive such information. Fres must be in place to provide the individual directly at the individual directly at the individual directly at the esuscitate Order (DDNR) was at residents (Resident #106). Filled to ensure the Virginia alth Durable Do Not (DDNR) was complete and ent #106.	F	578	directives to insure that the proper's has been explained and that written notification has been placed in the medical record. Systemic Change(s); The Facility policy and procedure we reviewed and no changes are warrarthis time. The Admissions Director been inserviced on the proper compof a DDNR and Advance Directives required. The Admission Director we discuss with each future Admission advance directors and resuscitation upon admission to the facility. Any/concerns expressed will be reported Administrator. The Administrator & Director of Nursing will speak to the concerned or with questions about a area & follow through on all concernsure proper resuscitation status is reflected in the medical record. Monitoring: The Admission Director and Social Services Director are responsible for maintaining compliance. The Administrator for place of the proper advance directive Any/all negative findings will be reported to the Administrator for immediate correct action to include an investigation. Completion Date: 07/06/18	ras nted at has letion when fill their status fall to the cose each ms to	
	The findings included	et e	i i	l			
l	The clinical record	of Resident #106 was					

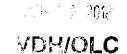
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reviewed 5/22/18 through 5/24/18. Resident

Event ID: B98C11

Facility ID: VA0117

If continuation sheet Page 2 of 14



PRINTED: 06/08/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL TAZEWELL XXXIID SUMMARY STATEMENT OF DEFICIENCIES PREFERY TAG Continued From page 2 #106 was admitted to the facility 4/24/18 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, cognitive communication deficit, hyperlipidemia, anxiety, heart failure, osteoarthritis, metabolic encephalopathy, chronic kidney disease, major depressive disorder, history of falls, left artificial hip joint, Type 2 diabetes mellitus, urinary tract infection, unspecified yearned with an assessment with an assessment reference date (ARD) of 51/18 assessed the resident with a BIMS (brief interview for mental status) as 3 out of 15. Resident #106's clinical record had a Virginia Department of Health DDNR rorm dated 4/30/18 and signed by the rurse practitioner and the power of attorney. Under section 1, the DDNR read in part, "I further certify (must check 1 or 2): 1. The patient is INCAPABLE of making an informed decision" The boxes beside #1 and #2 had been left blank. Section 2 read "If you checked 2 above, check A, B, or C below." The three boxes below had also been left blank.	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 10 mm		ONSTRUCTION		TE SURVEY MPLETED
HERITAGE HALL TAZEWELL SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE PREFIX PREFIX TAGE PROPRIATE DEFICIENCY			495152	B. WING			05	/24/2018
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 578 Continued From page 2 #106 was admitted to the facility 4/24/18 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, cognitive communication deficit, hyperipidemia, arxiety, heart failure, osteoarthritis, metabolic encephalopathy, chronic kidney disease, major depressive disorder, history of falls, left artificial hip joint, Type 2 diabetes mellitus, urinary tract infection, unspecified psychosis, peripheral vascular disease, pressure ulcer left heel, unstageable, pressure ulcer right heel, unstageable, and pressure ulcer, coccyx, stage 2. Resident #106's admission minimum data set (MDS) assessment with a BIMS (brief interview for mental status) as 3 out of 15. Resident #106's clinical record had a Virginia Department of Health DDNR form dated 4/30/18 and signed by the nurse practitioner and the power of attorney. Under section 1, the DDNR read in part, "I further certify (must check 1 or 2): 1. The patient is CAPABLE of making an informed decision 2. The patient is INCAPABLE of making an informed decision 2. The patient is INCAPABLE of making an informed decision The boxes beside #1 and #2 had been left blank. Section 2 read "if you checked 2 above, check A, B, or C below:" The three boxes below had also				8	121 E	BEN BOLT AVENUE	1	
#106 was admitted to the facility 4/24/18 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, cognitive communication deficit, hyperlipidemia, anxiety, heart failure, osteoarthritis, metabolic encephalopathy, chronic kidney disease, major depressive disorder, history of falls, left artificial hip joint, Type 2 diabetes mellitus, urinary tract infection, unspecified psychosis, peripheral vascular disease, pressure ulcer left heel, unstageable, pressure ulcer right heel, unstageable, and pressure ulcer, coccyx, stage 2. Resident #106's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/1/18 assessed the resident with a BIMS (brief interview for mental status) as 3 out of 15. Resident #106's clinical record had a Virginia Department of Health DDNR form dated 4/30/18 and signed by the nurse practitioner and the power of attorney. Under section 1, the DDNR read in part, "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision" The boxes beside #1 and #2 had been left blank. Section 2 read "If you checked 2 above, check A, B, or C below." The three boxes below had also	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
#106 was admitted to the facility 4/24/18 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, cognitive communication deficit, hyperlipidemia, anxiety, heart failure, osteoarthritis, metabolic encephalopathy, chronic kidney disease, major depressive disorder, history of falls, left artificial hip joint, Type 2 diabetes mellitus, urinary tract infection, unspecified psychosis, peripheral vascular disease, pressure ulcer left heel, unstageable, pressure ulcer right heel, unstageable, and pressure ulcer, coccyx, stage 2. Resident #106's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/1/18 assessed the resident with a BIMS (brief interview for mental status) as 3 out of 15. Resident #106's clinical record had a Virginia Department of Health DDNR form dated 4/30/18 and signed by the nurse practitioner and the power of attorney. Under section 1, the DDNR read in part, "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision" The boxes beside #1 and #2 had been left blank. Section 2 read "If you checked 2 above, check A, B, or C below." The three boxes below had also	E 570	Continued From D	200.2	:	570		्री -	l
Resident #106's clinical record had a Virginia Department of Health DDNR form dated 4/30/18 and signed by the nurse practitioner and the power of attorney. Under section 1, the DDNR read in part, "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision 2. The patient is INCAPABLE of making an informed decision" The boxes beside #1 and #2 had been left blank. Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below had also	r 310	#106 was admitted diagnoses that inclunspecified demer disturbances, cogribyperlipidemia, and osteoarthritis, metakidney disease, mahistory of falls, left diabetes mellitus, unspecified psychologiease, pressure pressure ulcer right pressure ulcer, compressure ulcer, compressure ulcer, compressure disease, pressure reference date (AF) resident with a BIM	It to the facility 4/24/18 with luded but not limited to natia with behavioral nitive communication deficit, exiety, heart failure, abolic encephalopathy, chronic ajor depressive disorder, artificial hip joint, Type 2 urinary tract infection, osis, peripheral vascular ulcer left heel, unstageable, at heel, unstageable, and ocyx, stage 2. Idmission minimum data set of with an assessment RD) of 5/1/18 assessed the MS (brief interview for mental					
Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below had also		Department of Heand signed by the power of attorney. Under section 1, the certify (must chech 1. The patient is informed decision 2. The patient is informed decision decisio	alth DDNR form dated 4/30/18 nurse practitioner and the he DDNR read in part, "I further k 1 or 2]: CAPABLE of making an INCAPABLE of making an"	1				
		Section 2 read "If B, or C below:" Th	you checked 2 above, check A,					

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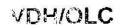
The surveyor informed the director of nursing of

Event ID: B98C11

Facility ID: VA0117

If continuation sheet Page 3 of 14





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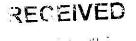
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		495152	B. WING		05/24/2018
	PROVIDER OR SUPPLIER SE HALL TAZEWELL		121 1	ET ADDRESS, CITY, STATE, ZIP CODE BEN BOLT AVENUE EWELL, VA 24651	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 578	DON stated the Di upon admission to	on 5/23/18 at 4:33 p.m. The DNR was usually completed the facility. The DON DDNR form was not	F 578		
	director of nursing #106's DDNR on the No further information	med the administrator and the of the concern with Resident 5/23/18 at 5:13 p.m.	**************************************		
	exit conference o Pharmacy Srvcs/ SS=D CFR(s): 483.45(a §483.45 Pharmac The facility must i drugs and biologi	Procedures/Pharmacist/Records n(b)(1)-(3)	F 755	F755 Corrective Action(s): The unused medication identified during medication cart review for unit 2 has be removed and properly disposed of. A facility Incident and Accident form has been completed for this incident.	een
	§483.70(g). The fine personnel to administration permits, but only to a licensed nurse. §483.45(a) Proceipharmaceutical set that assure the addispensing, and a	dures. A facility must provide ervices (including procedures curate acquiring, receiving, dministering of all drugs and et the needs of each resident.		Identification of Deficient Practices Corrective Action(s): All medication carts and medication rooms may have potentially been affer A 100% review of all medication carts and medication rooms has been condu- by the DON, ADON and/ or Unit managers to identify any unused medication not properly removed and disposed of. Any unused medication identified in medication carts or	eted. s acted
		e Consultation. The facility btain the services of a licensed		medication rooms will be removed ar properly disposed of, A facility Incid- and Accident form has been complete for each.	ent .
		ovides consultation on all ovision of pharmacy services in	11		н

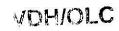
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Event ID: B98C11

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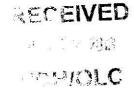
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The Committee of the Co		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495152	B. WING			05	/24/2018
	PROVIDER OR SUPPLIER BE HALL TAZEWELL			121	REET ADDRESS, CITY, STATE, ZIP CODE I BEN BOLT AVENUE ZEWELL, VA 24651		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 755	receipt and disposi sufficient detail to e reconciliation; and §483.45(b)(3) Dete order and that an a is maintained and partial This REQUIREME by: Based on observation document review, dispose of unused units (unit 2). The facility staff fair gentamicin after the course of antibiotic The findings included	blishes a system of records of tion of all controlled drugs in enable an accurate ermines that drug records are in account of all controlled drugs periodically reconciled. NT is not met as evidenced tion, staff interview, and facility the facility staff failed to medications on one of four led to dispose of a Residents e Resident had finished the etherapy. Ied. Proximately 12:30 p.m. while cation cart with LPN (licensed , the surveyor observed a n eye drops that belonged to a cility (Resident #89). These eye 03/29/18 and were to be a 7-day period. The EHR (electronic health orbalized to the surveyor that the proximately 2:15 p.m., the notified that the medication card medication (antibiotic) that		755	Systemic Changes: The Pharmacy Policy and Procedure been reviewed and no changes are warranted. All licensed nursing staff been inserviced on the Policy and Procedure for removal and destruction unused or discontinued resident medications from all medication car medication rooms. Monitoring: The DON is responsible for maintaic compliance. The DON, ADON or Umanager will conduct weekly audits medication carts and medication room onitor for compliance. All negative findings will be corrected at the time discovery. Results of the reviews we reported to the Quality Assurance. Committee for review, analysis, and recommendations for change in face policy, procedure, and/or practice. Completion Date: 07/06/18	on of the and	

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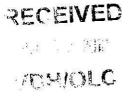
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495152	B. WING		05/24/2018
	ROVIDER OR SUPPLIER		121	REET ADDRESS, CITY, STATE, ZIP CODE I BEN BOLT AVENUE ZEWELL, VA 24651	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 755	their policy/proced Medications" on 05 read in part "Staff medications or sha dispensing pharma policy" No further informa provided to the sur	age 5 d the surveyor with a copy of ure titled "Discontinued 5/22/18 this policy/procedure shall destroy discontinued all return them to the acy in accordance with facility tion regarding this issue was evey team prior to the exit	F 755	ø	
	S483.20(f)(5) Resi (i) A facility may no resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use except to the exter to do so. §483.70(i) Medicar §483.70(i)(1) In accordance with a professional standard must maintain methat are- (i) Complete; (ii) Accurately doce (iii) Readily acces (iv) Systematically §483.70(i)(2) The all information cor	dent-identifiable information. In the release information that is the to the public. In release information that is the total agent only in contract under which the agent or disclose the information of the facility itself is permitted. If records. It records with accepted lards and practices, the facility dical records on each resident unmented; sible; and organized. If acility must keep confidential intained in the resident's records, form or storage method of the	F 842	Corrective Action(s): Resident #106's attending physicial been notified that the facility staff to accurately document resident #10 weekly skin inspection as not intact facility Incident & Accident form here completed for this incident. Identification of Deficient Practic Corrective Action(s): All other residents may have potent been affected. A 100% review of a current resident weekly skin inspection will be conducted by the DON, All and/or Unit Managers to identify at risk. All negative findings will correct as applicable at time of dist A facility Incident & Accident for the completed for each negative findings will be completed for each negative findings are warranted at this time. All license nursing staff will be inserviced by DON on the clinical documentation standards per facility policy and procedure. This training will inclusted and ards for maintaining accurate.	ces & ces & cially all ctions DON, residents be scovery. rm will nding. has e ed y the on ude the

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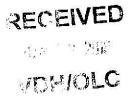
AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495152	B. WING		05/24/2018
	PROVIDER OR SUPPLIER SE HALL TAZEWELL			STREET ADDRESS, CITY, STATE, Z 121 BEN BOLT AVENUE TAZEWELL, VA 24651	IP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TON SHOULD BE COMPLÉTION THE APPROPRIATE DATE
F 842	(ii) Required by Lav (iii) For treatment, operations, as perr with 45 CFR 164.5 (iv) For public heal neglect, or domest activities, judicial a law enforcement p purposes, research medical examiners a serious threat to by and in compliant §483.70(i)(3) The frecord information unauthorized use.	, or their resident fre permitted by applicable law; w; payment, or health care mitted by and in compliance		medical records and clin documentation to include skin inspections accordin acceptable professional spractices. Monitoring: The DON is responsible compliance. The DON, designee will conduct we coinciding with the care monitor for compliance. findings will be clarified time of discovery and diwiff be taken as needed. this audit will be provid Assurance Committee for recommendations for chapolicy, procedure, and/or Completion Date: 07/0	for maintaining ADON and/or eekly chart audits plan schedule to Any/all negative d and corrected at isciplinary action The results of ed to the Quality or analysis and nange in facility or practice.
	for- (i) The period of tir (ii) Five years from there is no require (iii) For a minor, 3 legal age under St §483.70(i)(5) The (i) Sufficient inform (ii) A record of the (iii) The comprehe provided; (iv) The results of and resident revie determinations co	ne required by State law; or the date of discharge when ment in State law; or years after a resident reaches ate law. medical record must containation to identify the resident; resident's assessments; nsive plan of care and services any preadmission screening we valuations and nducted by the State; rse's, and other licensed	76 Gaz 200 100 100 100 100 100 100 100 100 100		
		diology and other diagnostic		2	on g

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Event ID: B98C11

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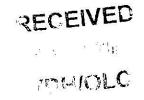
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE : COMPL	
		495152	B. WING		05/2	4/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 121 BEN BOLT AVENUE TAZEWELL, VA 24651	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 842	This REQUIREMS by: Based on staff in review, and clinical failed to ensure the was accurate for #106).	s required under §483.50. ENT is not met as evidenced terview, facility document al record review, the facility staff the 5/15/18 skin inspection sheet 1 of 31 residents (Resident alled to ensure the 5/15/18 skin was accurate for Resident #106.	F 84	12		
	The clinical record reviewed 5/22/18 #106 was admitted diagnoses that included in the control of	d of Resident #106 was through 5/24/18. Resident of the facility 4/24/18 with cluded but not limited to entia with behavioral unitive communication deficit, naxiety, heart failure, tabolic encephalopathy, chronic najor depressive disorder, at artificial hip joint, Type 2 urinary tract infection, nosis, peripheral vascular ender left heel, unstageable, with heel, unstageable, and			E	
V.	(MDS) assessme reference date (A resident with a BI status) as 3 out of assessed the respressure ulcers a	admission minimum data set ant with an assessment armore in the ARD) of 5/1/18 assessed the MS (brief interview for mental of 15. Section M Skin Conditions ident to be at risk for developing and was assessed with two (2) op tissue injury ulcers.	6 2			N.

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495152	B. WING			0:	5/24/2018
	PROVIDER OR SUPPLIER SE HALL TAZEWELL			121	EET ADDRESS, CITY, STATE, ZIP CODI BEN BOLT AVENUE ZEWELL, VA 24651	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
	5/2/18 identified Rewith skin due to de #106 has SDTI (de left heels. Approach frequently.	age 8 ehensive care plan dated esident #106 to have a problem creased mobility. Resident eep tissue injury) on right and ches were to monitor skin wed the weekly skin inspection	0	342			
	The wound assess identified a stage 2 #106's coccyx that The wound assess had small serous of	8. The skin inspection report)				
	inspection was ina was not intact. Th Resident #106 was facility and an inter	n on the 5/15/18 skin ccurate. Resident #106's skin e nurse that assessed s no longer employed at the view could not be done.					
	director of nursing #106's skin assess	of the concern with Resident sment documentation on n. and requested the facility	1				I.
0	Documentation" w policy read in part medical record will or speculative), co	itled "Charting and as reviewed 5/24/18. The "3. Documentation in the I be objective (not opinionated mplete and accurate."	i i				1 1
	exit conference on	tion was provided prior to the 5/24/18.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200000000000000000000000000000000000000		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495152	B. WING		<u> </u>	05/24/2018
NAME OF PROVIDER OR SUPPL	IER	71-22	STRI	EET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE HALL TAZEWE	ELL		100000000000000000000000000000000000000	BEN BOLT AVENUE EWELL, VA 24651	
CHMMAD	STATEMENT OF DEFICIENCIES	ı ID	<u> </u>	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX (EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF	2000000 (1990)	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 880 Continued Fron	n nage 9	F	880		I
F 880 Infection Preve	,		880	F880	
SS=D , CFR(s): 483.80		1	000	Corrective Action(s):	
55=D , Cl 1(s). 465.60			I)	The attending physician for Resident #6)2
§483.80 Infection	on Control	8	Ĭ.	was notified that C.N.A. #1 failed to	100
	st establish and maintain an	Ü	8	appropriately apply the Isolation Person Protective Equipment (PPE) prior to	iai
	ntion and control program	93	₩.	delivering care in the resident's room.	Ĵ
	ovide a safe, sanitary and			C.N.A. #1 has been inserviced by the	j.
	vironment and to help prevent the	78	30	DON on the proper contact isolation	
	nd transmission of communicable	8	1	procedures and the proper application of	of .
diseases and ir		I)	ř	the Personal Protective Equipment to b	e .
6		ii	į.	utilized when assisting residents on	100
	ection prevention and control	1	l E	isolation precautions	9
program.	- Land Calana infantian againstian	1	ī	Identification of Deficient Practice(s)
	st establish an infection prevention	E	18	and Corrective Action(s):	Ü
	gram (IPCP) that must include, at	20	18	All other residents on isolation	概
a minimum, me	e following elements:	E.	Î	precautions may have potentially been affected. A 100% review of all residen	nts
. 8483 80(2)(1)	A system for preventing, identifying	e e		on isolation will be conducted to ident	ify
	stigating, and controlling infections	l	:\$:8	any staff members entering isolation	
	able diseases for all residents,			rooms without the appropriate required	i '
	s, visitors, and other individuals	1	11	PPE. Any/all negative findings related	to
	ces under a contractual	Ţ		improper use of PPE will be corrected	at
	ased upon the facility assessment	ì	ĺ	time of discovery and one-on-one	Sal.
	ording to §483.70(e) and following	N.	1	inservice training will be completed we each employee. A facility Incident &	iii
accepted natio			11	Accident form will be completed for e	ach
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	T .	3	negative finding.	1
§483.80(a)(2)	Written standards, policies, and	i	89	negative imanig.	
	the program, which must include,			Systemic Change(s):	
but are not limi			1	The facility Infection Control policy a	л
(i) A system of	surveillance designed to identify	3	- 1	procedure has been reviewed and no	<u> </u>
possible comm	nunicable diseases or			changes are warranted at this time. Al	i a
	re they can spread to other	3	ř	staff will be inserviced by the DON and/or Regional Nurse Consultant on	the
persons in the	1404010E 181 AX 180 GARAC	1	10 20	infection Control Policy and procedur	re to
	to whom possible incidents of	ă.	677	include the standard for isolation	2000 C (2000 C))))))))))))))))))))))))))))))))))
20	disease or infections should be		10	precautions, proper application and	**
reported;	G 57 8 52 10 1001		10)	removal of PPE and hand washing to	
	ind transmission-based precautions	5 .		prevent the spread or infections befor	e
to be followed	to prevent spread of infections;	n		leaving all isolation rooms.	

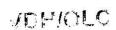
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Facility ID: VA0117

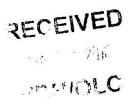
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD			(X3) DATE SURVEY COMPLETED	
	495152	B. WING			O.	5/24/2018
NAME OF PROVIDER OR SUPPLIER	5,40,600,000,000	61 60 - 3072	STR	EET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
HERITAGE HALL TAZEWELL			Tel Chestonia	BEN BOLT AVENUE ZEWELL, VA 24651		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROVIDER OF THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETION DATE
			31			
resident; including (A) The type and of depending upon the involved, and (B) A requirement least restrictive posticumstances. (v) The circumstant must prohibit empodisease or infected contact with reside contact will transmoved (vi)The hand hygical by staff involved in §483.80(a)(4) A system identified under the involved of the involved in the inv	isolation should be used for a	: ! L	880	Monitoring: The DON is responsible for maintage compliance. The DON and/or ADO perform random weekly audits of resident requiring isolation to mor appropriate use of PPE with all resin isolation. Any/all negative finding be corrected at the time of discoved disciplinary action will be taken a warranted. Aggregate findings of reports will be submitted to the Q Assurance Committee quarterly for review, analysis, and recommend for change in the facility policy as procedure. Compliance Date: 07/06/18	ON will all all nitor for sidents ings will ery and s the uality or ations	
	andle, store, process, and as to prevent the spread of		I I			n n
IPCP and update This REQUIREMS by: Based on observ document review,	nduct an annual review of its their program, as necessary. ENT is not met as evidenced ation, staff interview, and facility the facility staff failed to ensure ion control program for one of	• •	3 3 3			
(personal protecti	vear the appropriate PPE ve equipment) when providing #62. Resident #62 was on	a S	w			



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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCT		(X3) DATE SURVEY COMPLETED	
	75	495152	B. WING			05	/24/2018
	PROVIDER OR SUPPLIER			STREET ADDRE 121 BEN BOLT TAZEWELL,		DE	
(X4) ID . PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORR H CORRECTIVE ACTION SI REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	Continued From p	age 11	F8	880			4
	The findings include	ded:		g r			
	03/28/18. Diagnos limited to, VRE (va enterococci), hear hypothyroidism, m generalized anxiet	been re-admitted to the facility es included, but were not ancomycin resistant t failure, essential hypertension, ajor depressive disorder, y disorder, and bipolar					
	significant change set) assessment v reference date) of	ve patterns) of the Resident's in status MDS (minimum data vith an ARD (assessment 04/13/18 included a BIMS	I I	7 1 1 1			e 4
	of 15. Section G (indicate the Resid	mental status) summary score functional status) was coded to ent did not have any limitation in the upper or lower extremity.	1] 1			8
		ently had an order for contact OVRE. This order was dated	i i				
	surveyor observed assistant) #1 in th	proximately 11:55 a.m., the d CNA (certified nursing e Residents room. This CNA ny PPE. CNA #1 was observed	# 11 32		150		10 10 10
	bed table around	oving the Resident's over the using their bare hands. CNA #1 shing their hands prior to ents room.	5	ë E			
	, #1 about their lac the surveyor that already removed When asked abou	oom, the surveyor asked CNA of PPE. CNA#1 verbalized to the had gloves on but had them and thrown them away. It touching and moving the entert have					g.

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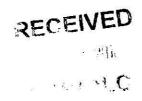
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495152	B. WING		05/24/2018
NAME OF I	PROVIDER OR SUPPLIER	₹	ST	REET ADDRESS, CITY, STATE, ZIP C	CODE
HERITAC	GE HALL TAZEWELI		121 BEN BOLT AVENUE		
16-1-1	10 10 10 10 10 10 10 10 10 10 10 10 10 1			ZEWELL, VA 24651	DDF-07-10N
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX : TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 880	Continued From p	page 12	F 880		
	hands. CNA #1 stated he did not want to touch		1		es T
		able with the gloves on.	1		*
			i	-	
	Per the CDC (centers for disease control and		P		#
	prevention) website https://www.cdc.gov/HAI/organisms/vre/vre.html		e e		Ħ
	accessed 05/23/18 "VRE is often passed from		£1		ii
	person to person by the contaminated hands of		į.		5
	caregivers. VRE can get onto a caregiver's hands		1		
	after they have contact with other people with		<u> </u>		I
	VRE or after contact with contaminated surfaces.		T		I
	VRE can also be spread directly to people after		. I		
	they touch surfaces that are contaminated with		E E		
		spread through the air by			3
	coughing or sneezing"		E		
			9		26
		histrator was notified of the	1		
		05/22/18 at approximately 1:15	*		
	₁ p.m.		į.		製
	The administrator	r provided the surveyor with a	· ·		10
		y policy/procedure regarding	: a		報
		ns on 05/22/18 this			
		read in part "Gloves and	; 1		
		addition to wearing gloves as			· ·
	outlined under St	andard Precautions, wear gloves			
		e) when entering the roomAfter	× 18		
	removing gloves and washing hands, do not		ĵi		*
		contaminated environmental	я		18
	surfaces or items	in the resident's room"	ï .		
	O= 05/00/49 at a	annovimataly 2:45 p.m. tha			No.
	On 05/22/18 at approximately 2:15 p.m., the surveyor interviewed the infection control nurse		2 9		100
		actical nurse) #2. When asked if	1		
1		e wearing gloves in a Residents	3		
16		contact isolation due to VRE.	0.7		
Ĕ	LPN #2 stated ye		1		
	oldiod ye	THE REPORT OF THE PERSON OF TH	3		19
90 13	No further inform	ation regarding this issue was	7		

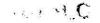
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495152	B. WING		05/24/2018_
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 121 BEN BOLT AVENUE TAZEWELL, VA 24651		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 880	Continued From pa	age 13	F 880		
	provided to the sur conference.	vey team prior to the exit			<u>I</u>
	i 				
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Event ID: 898C11

Facility ID: VA0117

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