PRINTED: 02/09/2016 FORM APPROVED OMB NO. 0938-0391

A 501DING C 495353 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 O(A) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	[' '	LE CONSTRUCTION	(X3) DATE SURVE COMPLETED	Y
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE XUMMARY STATEMENT OF DEFICIENCIES BLACKSTONE, VA 23824 YEAR DEFICIENCY MUST BE PRECEDED BY FILL TAKE	,				malauseminininkan (PM dassen dassen dassen (PM various provincia) on der state der state (PM various PM various provincia) on der state (PM various PM var	_	c
FOOD INITIAL COMMENTS				S 9	000 S MAIN ST	1 01/29/201	0
An unannounced Medicare/Medicaid standard survey was conducted 1/27/16 through 1/29/16. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 180 certified bed facility was 144 at the time of the survey. The survey sample consisted of 21 current resident reviews (Residents #1 through #21) and five closed record reviews (Residents #22 through #26). F 226 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Frace This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and employee record review, it was determined that the facility staff failed to complete background screenings for 4 of 5 employee records reviewed in accordance with the facility abuse policy. For OSM #12 (Other Staff Member, activities director), OSM #13 (dietary), LPN #11 (Licensed Practical Nurse), and CNA #11 (Certified Nursing Assistant) the facility staff failed to complete the directory, OSM #13 (dietary), LPN #11 (Licensed Practical Nurse), and CNA #11 (Certified Nursing Assistant) the facility staff failed to complete the directory, OSM #13 (dietary), LPN #11 (Licensed Practical Nurse), and CNA #11 (Certified Nursing Assistant) the facility staff failed to complete the directory in the facility staff failed to complete the directory in the facility staff failed to complete the directory in the facility staff failed to complete	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	D BE COMPLE	ETION
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Assistant) the facility staff failed to complete the		by: Based on staff intereview, and employ determined that the background screen records reviewed in abuse policy. For OSM #12 (Other director), OSM #13	rview, facility document ee record review, it was facility staff failed to complete ings for 4 of 5 employee accordance with the facility or Staff Member, activities (dietary), LPN #11 (Licensed		Identification of Deficient Practice Corrective Action(s): All other employees may have been potentially affected. The Human Resources department will audit 100 all active employee records to identi employees at risk. Any/all negative findings will be corrected at the time discovery. A Facility Incident and Accident Report will be completed if	0% of lify c of	
		30 day criminal bac	kground check with the		, ,	(X6) DATE	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date 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: VA0108

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		E SURVEY IPLETED
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F 226	required state ager required sworn stat conditions set forth not implemented. The findings include A review of the faci Check Policy" police Statement: In order productive environr residents, voluntee a policy and prograble required on any hired. This policy was 20141. Criminal conducted in accornance Applicants or employer asked to complete Authorization form corporation) to confire requested, the approvided with a concheck policy."	ncy; and failed to obtain the ement, both which were in the facility policy which was	F 2	26	Systemic Change(s): The facility policy and procedure been reviewed and no changes a warranted at this time. Administ Staff, Department Managers and department will be inserviced a copy of the policy & procedure Administrator. Administrative of Department Heads extending en without meeting the requirement established facility policy & provided facility procedure, facility practice.	are trative d the HR nd issued a by the Staff and mployment nts of the ocedure . t be red hed. er is simpliance. or and/or y audits of reach e. The hudits and he Quality hew, has for and/or and/or and/or and/or	
	from the last 4 mor conducted. Of thes the 30 day backgrostate agency; and contact statement, per applicate last the facility company to conduct addition, the form the sworn statement diregarding the application.	stiths prior to survey was see records, 4 did not contain and check from the required did not contain a sworn licable laws and facility policy. was using a third party at the background check. In that was being utilized as a d not include any statements cant was free from convictions and did not have any			,	RECE FER 18	VED

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	CON	TE SURVEY MPLETED C
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	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		
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F 226	pending charges. I statements that the procurement of a coreporting agency as background investig consumer report will about employment criminal history, cremode of living, charauthorizes all corporational institution justice agencies, cit courts, state motor to release any infor (applicant) and furth consumer investigat any time, any nurand after employment any and all liability for the procure of the procu	nstead, this form documented applicant authorizes the consumer report by a credit is part of the pre-screening gation; an investigative nich may contain information and educational background, dit, workers comp claims, racter, personal reputation; rations, companies, former sors, credit agencies, ons, law enforcement/criminal ty, state, county, and federal vehicle bureaus and persons mation they may have about her authorize that these tive reports may be procured mber of times, before, during ent; and stated that the eless all parties involved from for damages arising from any or furnishing the requested	F 2:	26		
	conducted with OSI and payroll.) She s (2015) the facility be agency for conduction and that she had question sworn statements the stated that as of "the (approximately the facility began to agency for backgrous statement that was what the third party the 4 records review	p.m., an interview was M #5 (HR [Human Resources] tated that around mid-October egan using a third party ing these required screenings and hat were being utilized. She ree weeks ago" beginning of January 2016) again use the required und checks and the sworn required by law, in addition to agency was doing, but that for wed, there was no further a screenings were conducted				

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
AND PLAN O	FCORRECTION	160 2014 () 11 (107) (107) (1 (107) (1 (107) (107) (1 (107) (1 (107) (107) (1 (107) (107) (1 (107) (1	A. BUILD	ING			c
		495353	B. WING			01/2	29/2016
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F 248	solely by the third pof mid-October 2012016. On 1/28/16 at the eapproximately 5:30 #1 (Administrative/CAdministrator), ASIRN #1 (Registered of Nursing), and ASIC CONSULTANT WERE OF NUTSING WITTER OF ACTIVE INTERESTS/NEED The facility must prof activities designed the comprehensive the physical, mentatof each resident. This REQUIREMED Based on observation documentation revifacility staff failed to the needs and intented the survey sample; The Facility staff failed to the needs and intented the survey sample;	earty agency during the period 5 to the beginning of January and of day meeting at p.m., the ASM Corporate Staff, the M #2 (the Director of Nursing), Nurse, the Assistant Director SM #3 (the regional nurse ade aware of the findings. No was provided by the end of the TITIES MEET DS OF EACH RES rovide for an ongoing program and to meet, in accordance with assessment, the interests and all, and psychosocial well-being NT is not met as evidenced tion, staff interview, facility lew and clinical record review of provide activities that meet rests of one of 26 residents in Resident #7.		226	F248 Corrective Action(s): Resident #7 has been reassessed for activities. Resident #7's plan of comparison updated to reflect her activity need interests with appropriate intervent meet her needs. Identification of Deficient Pract Corrective Action(s): All other residents with severe confimpairment may have been potent affected. The facility conducted a review of all severely cognitive resto identify residents at risk. Resididentified at risk will have their careviewed to determine if the residicate plan has activities listed to make resident's individual psychosocial and interests. Any changes or addifindings will be added to their resispecific care plan.	ice(s) & gnitive tially 100% esidents dents ent's eet the I needs itional ident	
	Resident #7 was a and readmitted on	dmitted to the facility on 8/4/15 12/11/15 with diagnoses that			gador grave ge Grav grav grav Grav grav	CEIVI MAR 200	

Facility ID: VA0108

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	A	
				9	00 S MAIN ST		
HERITA	GE HALL BLACKSTO	NE		В	BLACKSTONE, VA 23824		
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F 248	type two diabetes, s swallowing), severe and muscle weakner recent MDS (minim change assessmen reference date) of 1 coded as never und being understood b Resident #7 was compaired in the ability The resident was compaired in the ability and the resident on staff eating, personal hypersonal hypers	itted to high blood pressure, stroke, dysphagia (difficulty peripheral vascular disease ess. Resident #7's most um data set) was a significant at with an ARD (assessment 12/18/15. The resident was derstanding others and never y others for communication. It with an ARD (assessment 12/18/15. The resident was derstanding others and never y others for communication. It was being severely to make daily decisions. It was being totally with transfers, dressing, giene and bathing. In swere made of Resident #7 es: In Resident #7 was lying in open and non-verbal. TV was music playing. Resident #7 e ceiling. In Resident #7 was sleeping in the re not in session at this time. In Resident #7 was not in the re not in session at this time. In Resident #7 was lying in and eyes open and ic, TV, or any other activities g made available to the Resident #7 was lying in bed music, TV or any other red being made available to the in pade available to the case of the case o	F2	248	Systemic Change(s): The current facility policy and procedulas been reviewed and no changes are warranted at this time. The current Activities Director and Activity Assist will review the Long Term Care regulation manual for providing activity and to develop activity programs to maintain specific needs and interests. Monitoring: The Activities Director is responsible maintaining compliance. Weekly audit activity coding on Comprehensive Miles assessments and activity care plans were be conducted by the Activity Director and/or RCC coinciding with the MDS calendar to monitor for compliance. An egative findings will be reported to Risk Management Committee for reverse Aggregate findings will be reported to QA Committee for review, analysis, recommendations of change in facility policy, procedure, or practice. Completion date: 3 - 14 - 16	ant ties eet for ts of DS ill All he iew. o the and	

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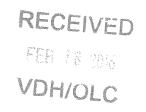
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AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING .		C	;
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F 248	activities were observed and ARD (assessme documented under Customary Routine "F0800. Staff Asserved and ARD (assessme documented under Customary Routine "F0800. Staff Asserved and Prefers: Owas documented "I. Family or signific discussions M. Listening to must. Participating in review of Resident documented in par "Provide resident will provide a MP3 choice for the residence for the residence for the resident of the company group activities." Review of the Januarevealed that Residence for the last and group activities. Review of Residence revealed her last and assistant on 1/13/1 documented the fogospel music; Durativities on 1/29/16 at apprinterview was conditional and the company of the province of the pr	a. No music, TV or any other erved being made available to the transport of trans		248			
	member) #14, the asked how often sl	activities assistant. When he visits Resident #7 for one to					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA ⁻ COI	(X3) DATE SURVEY COMPLETED	
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F 248	one activities she since steel ast time she vium as the last time she vium as the last time she vium activities Resident in just offer her activities as the last week asked if there was determine Resident stated, "Not that I as she refers to Reside activity preferences pointed to the care #7 did not have a M #14 stated, "I'm not in the office but she asked how Resider #14 stated that she kiosk and plays mustated that each acminutes. When as to see Resident #7 stated, "I actually loactivities with her. so I will visit her as asked if Resident # stated, "No." When "I think she is bedri was a way to find o	age 6 stated that she tries to see st once a week. When asked sited Resident #7 she stated, go." When asked what #7 likes to do she stated, "Well rities and she will shake her he wants to do the activity or a l painted her nails." When he reference she could use to t #7's likes or dislikes she he aware of." When asked if hent #7's MDS or care plan for he she stated, "No." When he plan and asked why Resident he state. We keep MP3 players he doesn't have one." When he comes in with a hand held he sic for the resident. She he tivity usually lasts 20-30 he dwhy she had not come in he week of survey she he st my handheld Kiosk to do he just found it today in my desk soon as possible." When he asked why, OSM #14 stated, he dden." When asked if there he ut how Resident #7 transfers he to once in the week of survey she he asked why, OSM #14 stated, he dden." When asked if there he asked why, OSM #14 stated, he dden." When asked if there he asked why, OSM #14 stated, he dden." When asked if there he asked why, OSM #14 stated, he dden." When asked if there he asked why, OSM #14 stated, he asked why when asked if the resident #15 when when when when when when when when	F2	248			
	conducted with LPN #12, the nurse on d asked if Resident # "No, she gets out o	a.m., an interview was N (licensed practical nurse) luty for Resident #7. When T is bedridden she stated, If the bed and into a reclining I her transfer status she stated			RECE		



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F 250 SS=D	Resident #7 needs Resident #7 would LPN #12 stated, "Ye an activity because now." The activities direct interview. On 1/29/16 at 10:00 made aware of the information was pro Facility policy titled, the following: "Goal and Purpose: of activities that mo physical, psycholog to establish a mean at (name of facility). The best way to lea residents will enjoy resident personally. and there are a few employees can use residents like and w participate inThe s analyses and asses Progress notes, Re- resident council me 483.15(g)(1) PROV RELATED SOCIAL The facility must pro services to attain or	a hoyer lift. When asked if benefit from group activities, es, I suppose she could go to she is becoming more alert or could not be reached for an amount a a.m., administration was above findings. No further wided during survey. "Activities" documents in part, To provide a diverse program tivate individuals to utilize their ical, and social attributes, and ingful life style while residing rn about which activities is to get to know each However, this can be difficult other sources Activities to learn about what activities to learn about what activities which ones they'll be able to sources include Activity sments, MDS, Care plan, cords of resident participation, etings." ISION OF MEDICALLY SERVICE	F 2		vsician for rvices. A			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	LTIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
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F 250	This REQUIREMEI by: Based on staff inter and clinical record the facility staff falls social services to not two of 26 residents Residents #9 and #1. The facility staff physician's order for Resident #9. 2. The facility staff physician's order for Resident #9. 2. The facility staff psychological service provider for Resident #9 was 10/7/11 with diagnostic history of a stroof his body; demended to: history of a stroof hist	erview, facility document review review, it was determined that ed to provide medically related neet the psychosocial needs of in the survey sample, #14. failed to follow-up on a or a psychological consult for a psychological consult for east #14. e: s admitted to the facility on oses including, but not limited oke with paralysis on one side that, psychosis, and major a most recent MDS (minimum ant change assessment with need that (ARD) 10/28/15, he g moderately impaired for one, having scored eight out of rief interview for mental oded as having demonstrated iors during the look back		250	comprehensive care plan has been reto reflect the current approaches and interventions to address his behavior Facility Incident & Accident Form I been completed for this incident. Resident #14 has been assessed by services and his attending physician the need for psychological services. referral for a psychological evaluati been ordered. Resident #14's comprehensive care plan has been reflect the current approaches and interventions to address his behavior Facility Incident & Accident Form been completed for this incident. Identification of Deficient Practice Corrective Action(s): All other residents who have orders psychiatric and/or psychological reand evaluations may have been pot affected. The social service directed conducted a 100% review of all reswith medically related psychosocial requiring psychiatric and/or psychological residents identified at risk will be Social Services for psychosocial interventions. All care plans will bupdated to reflect the current approand interventions.	rs. A lass social for A on has evised d lars. A has re(s) & for ferrals ential or will idents l needs ological risk. seen by	
	revealed the follow	ical record for Resident #9 ing physician's order, written nental health services					

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	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		90	0 S MAIN ST LACKSTONE, VA 23824			
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F 250	provider] to eval (experimental part) to eval (experimental part) to eval (experimental part) to evidence that this continuation of the vidence that this continuation of the surveyor sychological/ment #9. On 1/28/16 at 1:20 member) #3, the soft surveyor and gave the above-reference provider's letterheat 1/28/16. Review of part, the following: On April 24, 2015, [name of facility] to Health Services. Of determined this part service due to not it document was sign president of the me OSM #3 stated: "It they do not accept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who concept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who concept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who concept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who concept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who concept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who concept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who concept what the facility state another mental heat resident #9.	valuate) and treat." ne clinical record revealed no order had been followed. a.m., ASM (administrative the administrator, was asked to be with evidence of all tal health consults for Resident p.m., OSM (other staff pocial worker, approached the her a copy of a document with the document was dated of this document revealed, in "To Whom It May Concern: we received a referral from see [Resident #9] for Mental our Intake Department then the was not eligible for our having Medicare Part B." The med by an executive vice the health services company. They did not see him because his insurance." When asked of the first to be seen by the omes here to see residents." only started here July first ot communicate with me that g." When asked whose job it sidents receive needed mental the stated: "I guess it's my job to be sure it's done. I'll have them		250	Systemic Change(s): The Social Services director will readditional in-service training for identifying and providing psychosc support from the administrator. Social services will monitor all residents showing changes in behaviors, sign depression, and increased anxiety to provide timely and appropriate interventions to meet their psychosocial services will provide detailed monthly report to the Administrator documenting evider psychosocial support provided. Monitoring: The Administrator and the Social Director are responsible for maint compliance. The Social Service Director are resident records monthly coinciding with the MDS calendar monitor for compliance. The result these audits will be provided to to Quality Assurance Committee from analysis, and make recommendate change in facility policy, proceded and/or practice. Completion Date: 3-14-16	social sial as of cocial a acce of Services aining irector y to ts of he or review, tions for ure,		

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Event ID: K8DD11

Facility ID: VA0108

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CENTER	19 LOV MEDICYLE	a MEDICAID SERVICES				1	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ` '		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353	B. WING	;		01/	29/2016
	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	.0/2010
NAME OF	ROVIDER OR SUPPLIER			1	900 S MAIN ST		
HERITAG	E HALL BLACKSTO	NE		1	BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	Continued From pa	ge 10	F	250			
	Resident #9 dated revealed, in part, the by facility staff per Fand physician order moods/behaviors a On 1/28/16 at 5:30 staff member) #1, the director of nursing, consultant, and RN nursing, were informal to the staff member in the staff member	p.m., ASM (administrative he administrator, ASM #2, the ASM #3, the regional nurse #1, the assistant director of med of these concerns.					
	don't have that kind description for the solution document entitled "revealed, in part, the Services Director plant programs that facilitiand physiological was residentAssume residents to social, agencies. Docume records."	a.m., ASM #1 stated: "We of policy. We do have a job social worker." A review of the Social Services Director" e following: "The Social lans, organizes, and directs tate the social, psychological, ell-being of each responsibility for referral of health, and community nt referrals in resident on was provided prior to exit.					
	7/15/14 and most re with diagnoses inclu *Asperger syndromediabetes. On the m change assessmen	as admitted to the facility on ecently readmitted on 12/21/15 uding, but not limited to: e, **schizophrenia and lost recent MDS, a significant at with an ARD of 12/28/15, coded as having scored 15 out					

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PRINTED: 02/09/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DESCRIPTION SHIP IN INCOME.			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				-	goden jag varia paria pa	1	
		495353	B. WING			01/:	29/2016
	PROVIDER OR SUPPLIER SE HALL BLACKSTO	NE		900 S	ET ADDRESS, CITY, STATE, ZIP CODE S MAIN ST CKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 250	disorganized thinking directed toward oth period. A review of the physe #14 revealed the for "[Name of mental has devaluate) and treat services." Further review of the consult note from the provider dated 7/23 revealed, in part, the PLAN: Problem: Derefuses meds (meditalk therapyOffer PsychologyDischarmeds but is willing a very gregarious (tall On 1/28/16 at 1:20 member) #3, the soregarding the recompsychotherapy for Figust missed it." Where the providing resides recommended by period.	He was coded as having ng, as having verbal behaviors ers during the look-back sician's orders for Resident llowing order written 12/21/15: ealth services provider] to eval the for behavioral health service with the clinical record revealed a ne mental health service with service following: "TREATMENT epression. Plan: Pt (patient) dications) but is willing to get therapy services/refer to arge from my clinic as refusing to get psychotherapy and is kative)." p.m., OSM (other staff point worker, was interviewed namendation for further Resident #14. She stated: "I en asked what the process is not with psychotherapy as roviders, she stated: "I	F:	250	DEFICIENCY)		
	agency]. Then I giv a copy to follow up I need to put him or psychologist who pr facility]." She expla recommended the f #14 only does evalu- evaluator is not on f	om [name of evaluating re a copy to the unit and I keep on. I just missed this. I guess in the list for [name of rovides services at the ined that the provider who further therapy for Resident luations remotely - that is, the recility property and the one-distance via computer					

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Event ID: K8DD11

Facility ID: VA0108

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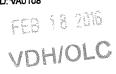
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PRINTED: 02/09/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DESCRIPCIONS (PACIT DESCRIPCION WAS THE PROCESSED BY SLLL (PACIT DESCRIPCION WAS	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
HERITAGE HALL BLACKSTONE CALL BLACKSTONE BLACKSTONE, VA 23824			495353	B. WING			01/2	9/2016	
PREFIX TAG F 250 Continued From page 12 technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 1/2/8/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. No further information was provided "*Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website http://www.ninds.nih.gov/hosthybublications/schiz ophrenia-booklet-12-2015/index.shtml F 252 F 252 SS=D F 253 F 254 SS=D Areview of the comprehensive care plan for Resident #11 stom fall mat has been replaced. A facility Incident & Accident form was completed for this incident.			NE		900	OS MAIN ST ACKSTONE, VA 23824			
technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. No further information was provided ""Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website http://www.ninds.nih.gov/disorders/asperger/asperger.htm. ""Schizophrenia is a chronic and severe disorder that affects how a person thinks, feels, and acts." This information is taken from the website http://www.nimh.nih.gov/health/publications/schiz ophrenia-booklet-12-2015/index.shtml F 252 SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	COMPLÉTION	
the resident to use his or her personal belongings	F 252	technology. She signed to be way of computer of the computer of the computer of the following: "Obstatus. Provide computer of the following: "Obstatus. The facility must provide computer of the following: "Obstatus." Schizophrenia is that affects how a This information is http://www.nimh.nophrenia-booklet-483.15(h)(1) SAFE/CLEAN/COENVIRONMENT	tated the evaluator and the objective or screens. Imprehensive care plan for d 12/28/15 revealed, in part, serve for changes in mental insistent caregiver." In p.m., ASM (administrative the administrator, ASM #2, the part, ASM #3, the regional nurse of these concerns. No was provided In	. F		Corrective Action(s): Resident #11's torn fall mat has replaced. A facility Incident & A	Accident		

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DEPARTM ENT OF HEALTH AND HUMAN SERVICES

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OCNITCE	EOP MEDICARE	& MEDICAID SERVICES					0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-		LE CONSTRUCTION		LETED
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		495353	B. WING			01/2	9/2016
	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	YEACH DESIGNENCY	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 APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Continued From pato the extent possili This REQUIREMED by: Based on observation document review a was determined the provide a clean, continued a clean, continued the provide a clean, continued the provide a clean, continued to the facility staff fatall mat in good resulting the findings included the findi	age 13 ble. NT is not met as evidenced ation, staff interview, facility and clinical record review, it at the facility staff failed to emfortable homelike ne of 26 residents in the survey #11. illed to maintain Resident #11's pair. de: admitted to the facility on loses that included but were not weakness, cardiac arrhythmia e rate or rhythm of your w blood pressure. Resident MDS (minimum data set), a nent with an ARD (assessment 12/24/15, coded the resident's daily decision making as being . Resident #11 was coded as ndent of one staff with a te of 6/18/15 documented, "Fall heck placement q (every) shift	F	252	Identification of Deficient Practice and Corrective Action(s): All other resident's utilizing fall may while bed may have potentially bee affected. A complete documented environmental walkthrough of the will be conducted by the administry maintenance director, and environs services director to identify resident risk. All resident fall mats identificate torn will be removed from service replaced immediately at the time of discovery. Systemic Change(s): The facility's policy & procedure providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warrant this time. The Maintenance Direct and/or Environmental Director with provide inservices to all staff on a policy and procedure on the notify system to use when repairs and clarence are needed throughout the facility. Monitoring: The Environmental Director and Maintenance Director is responsimal maintaining compliance. Docum facility rounds will be completed to monitor compliance. The adminishing are being corrected. Cut findings will be reported to the Cassurance Committee for review analysis, and recommendations.	ats en facility ator, mental ats at ed that vice and of for n ated at tor ill facility ication leaning deaning deanin	
	Resident #11 was	0 p.m. and 1/28/16 at 8:00 a.m. s observed in a wheel chair in Observation of Resident #11's e resident's fall mat was folded			change in facility policy, proced and/or practice Completion Date: 3-14-1	160	et Page 14 of

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Event ID: K8DD11

Facility ID: VA0108

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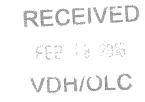
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	COM	E SURVEY MPLETED
		495353	B. WING		1	/29/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 252	and sitting against A torn area approx half inch wide was mat. Foam was explastic covering. On 1/28/16 at 1:32 conducted with CN #1. CNA #1 was a residents' fall mats without torn areas. torn we put in a woor go to the superv know." When asked areas on Resident she had not. CNA resident's fall mat when asked if Resident's fall mat when asked if Resident's fall mat when asked if Resident's he day shift only naps during the day shift only naps during the room fall the room. On 1/28/16 at 4:25 conducted with CN was responsible for clean and free from the didn't think am never seen anyone keep a torn fall mat CNA #2 stated, "I can anew one." On 1/28/16 at 5:52 staff member) #1 (the foot of the resident's bed. imately four inches long by one observed on the edge of the coosed sticking out of the p.m., an interview was lA (certified nursing assistant) sked how staff ensures are maintained in good repair CNA #1 stated, "If we see it ork request to have it changed risor and let the charge nurse ed if she had noticed any torn #11's fall mat, CNA #1 stated #1 stated she didn't use the and it was utilized by night shift. Sident #11 ever took naps to CNA #1 stated the resident he day once in a while. At this taken to Resident #11's room mat. CNA #1 stated she would mat and removed the mat from an interview was lA #2. CNA #2 was asked who are ensuring fall mats were kept in torn areas. CNA #2 stated yone did that and she had ed that. When asked how to it clean and free of bacteria, don't think you can. I would get the administrator) and ASM #2 sing) were made aware of the	F 2	52		

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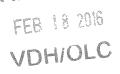
STATEMENT AND PLAN O	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353				1	29/2016
	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		900	REET ADDRESS, CITY, STATE, ZIP CODE DIS MAIN ST LACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 272 SS=B	Environment" docuprovided with a safthomelike environment management shall possible, the chara reflect a personaliz characteristics included order" No further information with the same of a comprehensive, a comprehensive, a reproducible assess functional capacity. A facility must make assessment of a resident assessment of a resident assessment of a register the following: Identification and docustomary routine; Cognitive patterns; Communication; Vision; Mood and behavior psychosocial well-	tled, "Quality of Life- Homelike mented in part, "Residents are e, clean, comfortable and ent2. The facility staff and maximize, to the extent cteristics of the facility that ed, homelike setting. These ude: a. Cleanliness and ion was presented prior to exit. as obtained from the website: n.gov/medlineplus/arrhythmia.h PREHENSIVE Induct initially and periodically accurate, standardized sment of each resident's esident's needs, using the ent instrument (RAI) specified assessment must include at emographic information;		272	F272 Corrective Action(s): Residents #4 & #12 identified in the survey sample have had their Care Assessment Summary revised to refit the date of the of documentation describing each resident's clinical sand other factors that may impact caplanning decisions. Identification of Deficient Practic Corrective Action(s): All other residents may have potent affected. A 100% review of all Car Assessment Summary's will be corby the RCC and/or designee to ider residents affected. All residents affected will have their Care Area Assessment Summary's corrected at time of dis	Area flect tatus are tes & tially re Area inpleted intify ected ent	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION		E SURVEY IPLETED
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILC	ING	and the state of t	1	С
		495353	B. WING			01/	/29/2016
	PROVIDER OR SUPPLIER	NE		900	REET ADDRESS, CITY, STATE, ZIP CODE S MAIN ST ACKSTONE, VA 23824		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 272	Disease diagnosis Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potentia Documentation of the additional asse areas triggered by Data Set (MDS); a Documentation of This REQUIREME by: Based on staff int review, it was dete failed to provide th (Care Area Assess the MDS (minimulation of 26 resident Residents # 4 and 1. The facility star location and date the resident's clinicare planning dec	and health conditions; nal status; and procedures; al; summary information regarding essment performed on the care the completion of the Minimum and participation in assessment. ENT is not met as evidenced erwiew and clinical record ermined that the facility staff are location and date on the CAA sment) summary worksheet of an data set) assessments for in the survey sample,		272	Systemic Change(s): The facility policy and procedure reviewed and no changes are warrithis time. The regional nurse conswill inservice the Resident Care Coordinator's and the interdisciplic Care Plan Team on accurately conthe Care Area Assessment Summawill include accurate documentation discating the date and location of documentation describing each reclinical status and other factors the impact care planning. Monitoring: The RCC is responsible for maint compliance. The RCC will comp MDS audit tool weekly coincidin the MDS calendar to monitor for compliance. Any/all negative find will be reported to the RCC and the time of discovery for imme correction. Aggregate findings we reported to the Quality Assurance Committee for review, analysis, a recommendations for changes in procedure, and/or facility practic Completion Date: 3 - 14 - 16	anted at ultant anary inpletely ary. This on sident's at aining lete g with dings he DON diate ill be e and policy, e.	
	assessment, with Reference Date)						
	2. The facility staf	f failed to document the location	1		16	- vetten obe	et Page 17 of 9

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495353	B. WING			1	C 29/2016	
	PROVIDER OR SUPPLIER		`	90	REET ADDRESS, CITY, STATE, ZIP CODE DIS MAIN ST LACKSTONE, VA 23824			
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 272	and date of the infresident's clinical scare planning decides Assessment (CAAMDS (Minimum Diassessment, with Reference Date) of The findings included. 1. Resident # 4 w 7/29/14 readmitted on 1/2 included, but were hypertension, hypertension, glaudedisease, coronary prostatic hypertromasses a quarter (Assessment Ref Resident # 4 was 15 on the Brief Included (BIMS), indicating cognitively impair Review of Reside comprehensive a change assessment revealed in Section information documents in the section of the sec	ormation describing the status and factors impacting sions on Section V-Care Area) Summary of Resident # 12's ata Set) a significant change an ARD (Assessment of 6/12/15. de: as admitted to the facility on do no 6/1/15 and again 6/16 with diagnoses that a not limited to: diabetes, erlipidemia, dementia, oma, gastroesophageal reflux artery disease, and benign only. ast recent MDS (Minimum Data rly assessment with an ARD erence Date) of 12/7/15. coded as an 8 out of a possible terview for Mental Status that the resident was ed. ant # 4's most recent essessment, the significant ent with an ARD of 6/8/15, on V - CAA, that dates of mented under the heading, the of CAA Information", was		272				
	Section A - CAA I Resident # 4 trigg Cognitive Loss/D Visual Function	results documented that gered the following CAA areas: ementia						

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	CON	E SURVEY APLETED C
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(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 272	Communication Urinary Incontinent Falls Nutritional Status Dehydration/Fluid Dental Care Pressure Ulcer Under the columns documentation" fo the location of the the CAA was docu Information was not Cognitive Loss/Devisual Function Dental Care During an interviet LPN (Licensed Pr Coordinator this N was asked about summary and LPt responded, "All th Resident's clinical dates in." LPN # to guide her with of (Registered Nurse responded, "We to Assessment Instr Section V of the N page the following "1. Check column 2. for each trigger a new care plan, continuation of columns and tress the prob-	Maintenance s, "Location and Date of CAA r the following triggered areas information used to complete mented but the date of the ot documented as instructed: mentia w on 1/28/16 at 11:50 a.m. with actical Nurse) # 1 an MDS MDS was reviewed. LPN # 1 the missing dates in the CAA N # 1, after reviewing the MDS, at information was in the record, I just didn't put the 1 was asked if she had a policy completion of Section V. RN e) #2, an MDS Coordinator, use the RAI (Resident ument) manual."	2	772		not Page 19 of

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	СОМ	SURVEY PLETED
1 Material Section 1		495353	B. WING			1	29/2016
	PROVIDER OR SUPPLIER			900	EET ADDRESS, CITY, STATE, ZIP COD S MAIN ST ACKSTONE, VA 23824	DE	
(X4) ID PREFIX	SUMMARY ST.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD RE	(X5) COMPLETION DATE
F 272	Continued From p the Care Plan colu days of completing Check column B it addressed in the c 3. Indicate in the L information colum the CAA can be for should include informations, risks and this care area." During an intervie ASM (Administrate Administrator, and Consultant, these	age 19 Imm must be completed within 7 Ig the RAI (MDS and CAA(s)). If the triggered care area is care plan. Location and Date of CAA In where information related to bund. CAA documentation ormation on the complicating any referrals for this resident for the Staff Member) # 1, the d ASM # 3, the Regional Nurse findings were shared.		272	DEFICIENCY		
	3/7/11 and readment that included, but heart failure, seize macular degener and arthritis. Resident # 12's reset) was a quarte (assessment reference Resident #12 was impaired for daily Review of Residence comprehensive a change assessment resident in Section 19 and 1	was admitted to the facility on nitted on 12/23/13 with diagnose were not limited to: congestive tures, hypertension, depression, ration, gout, Alzheimer's disease most recent MDS (minimum daterly assessment with an ARD erence date) of 12/11/15. It is coded as being severely decision making. ent # 12's most recent assessment, the significant ment with an ARD of 6/12/15, ion V - CAA, that dates of umented under the heading,) ,				

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Event ID: K8DD11

Facility ID: VA0108

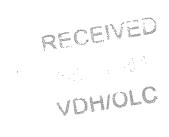






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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	COMF	PLETED
		495353	B. WING		1	29/2016
	ROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 272	Resident # 4 trigger Cognitive Loss/Der Visual Function Communication ADL Functional/Rel Urinary Incontinence Behavioral Sympton Activities Falls Nutritional Status Pressure Ulcer Psychotropic Drug Physical Restraints Under the columns documentation" for the location of the inthe CAA was docur information was not Visual Function Activities Nutritional Status During an interview LPN (Licensed Prace Coordinator, this M was asked about the summary and LPN responded, "All that Resident's clinical r dates in." LPN # 1 to guide her with co (Registered Nurse) responded, "We us	suits documented that red the following CAA areas: mentia habilitation Potential and Indwelling Catheter ms Use , "Location and Date of CAA the following triggered areas information used to complete mented but the date of the triggered areas instructed: on 1/28/16 at 11:50 a.m. with ctical Nurse) # 1, an MDS DS was reviewed. LPN # 1 in emissing dates in the CAA # 1, after reviewing the MDS, trinformation was in the record, I just didn't put the was asked if she had a policy ompletion of Section V. RN #2, an MDS Coordinator, we the RAI (resident	F2	272		
	assessment instrur	Obsolute Event ID: K8DD:	11	Facility ID: VA0108	If continuation shee	Page 21 of 99



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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY PLETED
	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COM	
		495353	B. WING			1	29/2016
NAME OF F	ROVIDER OR SUPPLIER	1			REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL BLACKSTO	NE) S MAIN ST ACKSTONE, VA 23824		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	- D		PROVIDER'S PLAN OF CORRECTION	N N DE	(X5) COMPLETION
PREFIX TAG	(EACH DEFICIENC) REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
F 272	Continued From pa	age 21	F2	272			
	ASM (Administrative Administrator, and	on 1/28/16 at 4:00 p.m. with re Staff Member) # 1, the ASM # 3, the Regional Nurse indings were shared.					
	No further informatend of the survey.	ion was provided prior to the		-			
F 278 SS=E	483 20(a) - (i) ASS	ESSMENT RDINATION/CERTIFIED	F2	278	F278 Corrective Action(s): Resident #11's Admission MDS Assessment with and ARD of 6/25/1	5 was	
	resident's status.	rust accurately reflect the			reviewed by the RCC and a modifical was completed to accurately code result 11'1 height.	ttion	The state of the s
	A registered nurse each assessment of participation of hea	must conduct or coordinate with the appropriate alth professionals.		And the second s	Resident #7's Significant Change M assessment with and ARD of 12/18/	15	
	A registered nurse assessment is con	must sign and certify that the pleted.			modification was completed to accurate code section C (cognitive patterns).	sment	
	Each individual whassessment must that portion of the a	o completes a portion of the sign and certify the accuracy of assessment.		All and the second seco	with and ARD of 11/20/15 was revi by the RCC and a modification was completed to accurately code sectio (Mood).	eweu	
	willfully and knowir false statement in subject to a civil me \$1,000 for each as willfully and knowir to certify a materia	nd Medicaid, an individual who negly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who negly causes another individual and false statement in a			Resident #5's Annual MDS assessment and ARD of 9/10/15 and quart MDS assessment were reviewed by RCC and modifications were comp to accurately code Cognition and conterviews for Mood.	the leted	
	penalty of not more assessment.	ent is subject to a civil money e than \$5,000 for each			Resident #12's Quarterly MDS assessment with and ARD of 12/11 was reviewed by the RCC and a modification was completed to acc		
	Clinical disagreem material and false	ent does not constitute a statement.	- Control of the Cont		code resident #11'1 Race/ethnicity		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
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,	PROVIDER OR SUPPLIER BE HALL BLACKSTON	VE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	DE	.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 278	This REQUIREMENt by: Based on staff interview, it was determined to maintain a (minimum data set) survey sample, Restailed to the interview sample, Restailed to the interview for the interview for section C (cognitive significant change (lassessment with an date) of 12/18/15. 2b. The facility staff interview for section quarterly MDS (minimum data assessment referentialed to conduct the quarterly MDS assessment referentialed to conduct the quarterly MDS assessment assessment referentialed to conduct the quarterly MDS assessmentialed to conduct the quarte	arview and clinical record mined that the facility staff complete and accurate MDS for four of 26 residents in the idents #11, #7, #5 and #12. Alled to code Resident #11's sion MDS assessment with not reference date) of 6/25/15. Failed to properly code patterns) of Resident #7's Minimum Data Set) ARD (assessment reference date) of mum data set) assessment sment reference date) of mum data set) assessment with an ce date (ARD) 9/10/15; and interview for mood on the sement with ARD 12/10/15. The facility staff failed to tion A 1000. Race/Ethnicity Quarterly MDS (Minimum ent with an ARD (Assessment with an ARD (Assessment)	F 2	Identification of Deficient Prand Corrective Action(s): All other residents may have be potentially been affected. A 10 of all current resident MDS as will be completed by the RCC designee to ensure that MDS section C – Co Patterns, section D - Mood intesection K – Height are assessed correctly. All negative findings reported to the RCC for immed correction. A Modification will completed for each discrepancy on the most current MDS. Systemic Change(s): The Resident Interdisciplinary have been inserviced by the Re, Nurse consultant on the proper assessment and interviewing an of all areas of the MDS to inclusections A, C, D, K of the MDS comprehensive MDS's and qual MDS's will now be reviewed eacording to the MDS schedule RCC and/or DON to ensure the and integrity of resident data.	een 00% auc sessmer and/or ections gnitive erview a d and co swill be liate l be v identi: Care Te gional d codin de All rterly ach wee by the	dit nts A and oded e fied eam	

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CENTER	S FUR MEDICARE	& WILDIOAD OLIVIOLO			CONCTRUCTION	(X3) D/	ITE SURVEY	
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED		
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER	A, BUILE	JING			С	
			B. WING			0	1/29/2016	
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NAME OF F	PROVIDER OR SUPPLIER			1	OO S MAIN ST			
UEDITAC	E HALL BLACKSTO	NE			LACKSTONE, VA 23824			
HERITAG			·			SECTION	(X5)	
(X4) ID PREFIX TAG	JEACH DESIGIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
F 278	Continued From pa	age 23	F	278	Monitoring: The DON and RCC are respon	nsible for		
	The findings include				monitoring compliance. The N	MDS		
					accessment audit will be comp	oleted		
	1. The facility staff	failed to code Resident #11's			weekly coinciding with the M	DS calendar		
	beight on the admi	ission MDS assessment with			to monitor for compliance. Al	ii negative		
	an ARD (assessm	ent reference date) of 6/25/15.			findings from the audits will to the DON and RCC at the ti	se reported		
	Docident #11 was	admitted to the facility on			discovery for immediate corre	ection.	E. Carriero and Ca	
	6/15/15 with diagn	oses that included but were not			Aggregate findings will be re-	portea to the		
	limited to: muscle	weakness, cardiac arrhythmia			Quality Assurance Committee	e monthly		
	(a problem with the	e rate or rhythm of your			for review analysis, and		as a service and the service a	
	heartheat*) and lo	w blood pressure. Resident			recommendations for change	in facility	-	
	#11's most recent	MDS (minimum data set), a			policy, procedure, and/or pra- Completion Date: 3 - 1	-16		
	quarterly assessm	ent with an ARD (assessment 12/24/15, coded the resident's			Completion Date. 3	10		
	cognitive skills for	daily decision making as being						
	severely impaired	·						
	Review of Reside	nt #11's admission MDS						
	assessment with a	an ARD of 6/25/15 revealed the					Link to the same of the same o	
		vas coded as "00" inches in						
	Section K.							
	On 4/20/46 of 44:	00 a.m., an interview was						
	conducted with RI	N (registered nurse) #2 (the						
	MDS coordinator)	RN #2 confirmed she dian't						
	code Resident #1	1's height on the admission						
	MDS assessment	RN #2 stated staff hadn't						
	obtained a height	on the resident and she should						
	have went and ob	tained the height herself. KN						
	#2 stated she refe	erences the RAI (Resident						
	Assessment Instr	ument) manual when						
	completing MDS	a>>c>>(1)C(1)S.						
	On 1/28/16 at 5:5	2 p.m., ASM (administrative						
	staff member) #1	(the administrator) and ASM #2						
	(the director of nu	ursing) were made aware of the						
	above findings.							
		rs for Medicare and Medicaid	1					
1	☐ The CMS (Center	rs for Medicare and Medicald						

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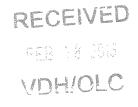
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURY COMPLETE	
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	PROVIDER OR SUPPLIER	NE		900 \$	EET ADDRESS, CITY, STATE, ZIP CODE S MAIN ST CKSTONE, VA 23824		
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F 278	"K0200: Height and "K0200: Height and Planning for Care · Height and weight with assessing the hydration status by monitoring stability time. The measure determining nutrition Steps for Assessm 1. Base height on the most recent and Measure and recon Coding Instruction · Record height to the No further informat *This information white hydration and https://www.nlm.ni tml 2a. The facility stat Section C (cognitive significant change assessment with a date) of 12/18/15. Resident #7 was a and readmitted on	ual documented the following: d Weight measurements assist staff resident's nutrition and providing a mechanism for of weight over a period of ment of weight is one guide for onal status. ment for K0200A, Height the most recent height since limission/entry or reentry. In height in inches It for K0200A, Height the nearest whole inch" It ion was presented prior to exit. It was obtained from the website: It h.gov/medlineplus/arrhythmia.h If failed to properly code we patterns) of Resident #7's (Minimum Data Set) an ARD (assessment reference admitted to the facility on 8/4/15 and 12/11/15 with diagnoses that					
	type two (II) diaber swallowing), sever	nited to: high blood pressure, tes, stroke, dysphagia (difficulty re peripheral vascular disease ness. Resident #7's most num data set) was a significant					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
				The second design of the secon		С
		495353	B. WING		01/	29/2016
	PROVIDER OR SUPPLIER 3E HALL BLACKSTO!	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE	(X5) COMPLETION DATE
	change assessmen The resident was co others and never be communication. Re severely impaired in decisions. The resident totally dependent or eating, personal hyg Review of Resident significant change a 12/18/15 revealed th Speech and Vision" following: "B0700. Makes Se express ideas and w and non-verbal expr 0. Understood 1. Usually understood some words or finish prompted or given th 2. Sometimes under making concrete reg 3. Rarely/Never unde A "3" was coded und resident was rarely u Section B0800. "Abil documented the follo "Understanding verb (with hearing aid or c 0. Understands-clear 1. Usually understand of message but com 2. Sometimes understand of simple, direct com 3. Rarely/never unde A "3" was coded indic or never understands	t with an ARD of 12/18/15. Indeed as never understanding bing understood by others for resident #7 was coded as being in the ability to make daily dent was coded as being in staff with transfers, dressing, giene and bathing. #7's most recent MDS, a ssessment with an ARD of the section B "Hearing, in part, documented the in part, documented the in part, documented the in part, documented the inderstood; Ability to wants, consider both verbal ression. In a consider both ression. In a consider both verbal ression. In a consider both ression. In a consider bot	F 2	278		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-	TIPLE CONSTRUCTION DING		OATE SURVEY OMPLETED
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F 278	"C0100. Should Bri (C0200-C0500) should tinterview vool. No (Resident is Skip to and complete Assessment for Medication of the State of Resident's cognitive C0500, "Summary documented the form of the State of Resident's cognitive C0500, "Summary documented the form of the State of C0200-C (00-15). Enter 99 if complete the interval of Complete the interval of Cognitive State of C0600, "Since of	ief Interview for Mental Status ould be conducted? Attempt to with all residents" rarely/never understood) —> sete C0700-C1000, Staff ental Status. In to C0200, Repetition of three ented indicating the individual to be attempted due to the estatus. Score" of cognitive status llowing: "Add scores for could and fill in total score if the resident was unable to view." Idocumented under C0500 ident #7 had a BIMS score of dividual interview had been staff assessment for Mental completed for Resident #7. oded a "3" under C1000 really decision making) ent was severely cognitively	F2	278		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION ING	(***CON	TE SURVEY MPLETED C
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. 4. (1.77)	PROVIDER OR SUPPLIER SE HALL BLACKSTO	NE		STREET ADDRESS, CITY, S 900 S MAIN ST BLACKSTONE, VA 23		
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F 278	made aware of the information was pro The RAI (Resident manual documents section "C0500: Su "Coding Instruction Record whether the attempted with the -Code 0, no: If the attempted because understood or an ir available. Skip to 0 Mental StatusCode 1, yes: If the because the reside understood verball interpreter is needed C0200, Repetition Code 99, unable to resident chooses no (b) if four or more if the resident choose	above findings. No further esented during survey. Assessment Instrument) in part the following under immary Score: s: e cognitive interview should be resident. interview should not be the resident is rarely/never enterpreter is needed but not coroo, Staff Assessment of interview should be attempted ent is at least sometimes by or in writing, and if an ed, one is available. Proceed to of Three Words o complete interview: if (a) the lot to participate in the BIMS, terms were coded 0 because not to answer or gave a line, or (c) if any of the BIMS	F	278		
	interview for sectio quarterly MDS (mir with an ARD (asset 11/20/15. Review of Residen quarterly assessme revealed that Secti Vision" in part, doc "B0700. Makes S	f failed to attempt a resident in D "Mood" on Resident #7's nimum data set) assessment issment reference date) of t #7's comprehensive MDS, a ent with an ARD of 11/20/15 on B "Hearing, Speech and umented the following: elf Understood, Ability to wants, consider both verbal pression.				

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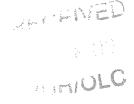
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	cx	(X3) DATE SURVEY COMPLETED	
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F 278	Continued From pa 1. Usually understo- some words or finis prompted or given to 2. Sometimes under making concrete recommends 3. Rarely/Never underesident was usually Section B0800. "Ab- documented the foll "Understanding verf (with hearing aid or 0. Understands-cleat 1. Usually understand of message but com 2. Sometimes understand of message but com 3. Rarely/never underestand A "2" was coded ind sometimes understand Section D (Mood), of following: "D0100. Should Resional Complet conducted? -Attempresidents. 0. No (resident is ranged) Assessment of Resional Complet Assessment of Resional Continues 1. Yes -> Continues	ge 28 od-difficulty communicating thing thoughts but is able if time. restood -ability is limited to quests. derstood." der B0700 indicating the y understood. illity to understand others" owing: bal content, however able device if used) ar comprehension ands-misses some part/intent aprehends most conversation. restands-responds adequately inmunication only. erstands." icating that the resident ands others. of the MDS documented the sident Mood Interview be at to conduct interview with all rely/never understood)> e D0500-D0600, Staff	F 2	DEFICIENCY)			
	indicating that the re understood. Section Resident Mood) was On 1/28/16 at 2:00 p conducted with RN (MDS coordinator. W of the MDS she state	d under section D0100 esident is rarely or never D0500 (Staff Assessment of completed. b.m., an interview was Registered nurse) # 2, the Vhen asked about section D ed, "That was my mistake; have been attempted.					

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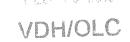
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F 278	should know better the RAI (resident as a reference who On 1/28/16 at 5:26 made aware of the information was properties and a section "D0100: Moreon the RAI (Resident manual documents section "D0100: Moreon the conduction of the conducted for reside understood, or who was not staff Assessment (PHQ-9-OV©). Code 1, yes: if the conducted. This or residents who are whom an interpret Continue to item E (PHQ-9©)." 3. The facility staff for cognition and reference to the conducted the conduction of the conducted the conduction of the conducted the conduction of the cond	r." RN #2 stated that she uses issessment instrument) manual en completing the MDS. In p.m., administration was above findings. No further resented during survey. Assessment Instrument) is in part the following under cood Assessment:" Ins: Code 0, no: if the interview ducted. This option should be ents who are rarely/never on need an interpreter (A1100 = available. Skip to item D0500, of Resident Mood resident interview should be ption should be selected for able to be understood, and for er is not needed or is present. 20200, Resident Mood Interview I failed to conduct the interviews mood on Resident #5's annual ata set) assessment with an ence date (ARD) 9/10/15; and the interview for mood on the sessment with ARD 12/10/15. Admitted to the facility on moses including, but not limited behaviors, anxiety and major the most recent MDS, a quarterly and ARD 12/10/15, Resident #5 the times understood by others		278				

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mp 22 27 200 0 - 100 - 1	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495353	B. WING			1	29/2016
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, S 900 S MAIN ST BLACKSTONE, VA 23			
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F 278	12/10/15 revealed to of Section C "Cogn Section C-0100 "Sh Status be Conducted evidenced by a "0" (enter "1" for "yes" interview and "0" for understood - skip to Assessment for Me was coded as "0" for The "Staff Assessment for Me was coded in Section Both A review of the announced the reside C "Cognition" was reconsulted the reside C "Cognition" was reconsulted the resident is rarely/recompleteStaff As The resident was completedStaff As The resident was completed the resident was completed the resident was completed the resident was completed the resident was code sometimes understood. The "Section C was completed the resident of "Should Resident Medical Resident Medical Resident Medical Resident Medical Resident is rarely/need resident resident resident resident resident residen	the resident interview portion lition" was not completed. Incould Brief Interview for Mental ad?" was coded "No" as in the box for this section - continue with resident or "no" - resident is rarely/never or and completeStaff and Status). The resident or rarely/never understood. In the conflicted with what was 10,700 - sometimes understood. In the conflicted with what was 10,700 - sometimes understood. In the completed. Section and completed. Section are coded "No" as evidenced by this section (enter "1" for "yes" dent interview and "0" for "no" never understood - skip to and in Section B0,700 - sod. In Section B0,700 - sec	F2				
	resident is rarely/ne completeStaff As	ent interview and "0" for "no" - ever understood - skip to and esessment for Mental Status). eded as "0" for rarely/never					

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Facility ID: VA0108

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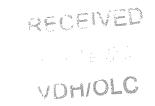
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION		SURVEY PLETED
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F 278	Continued From parenderstood. The "Section D was come with what was code sometimes understood. The "Management of the passessment of the passessme	ge 31 Staff Assessment" portion of pleted instead. This conflicted ad in Section B0700 - cood. Dia.m., RN (registered nurse) mator, was interviewed inflicts. When shown the portions of the MDS stated: "I should have coded erviews. I should have coded erviews, but could not finish e resident's abilities on that in on my part. I should have views." p.m., ASM (administrative the administrator, ASM #2, the ASM #3, the regional nurse #1, the assistant director of med of these concerns. On was provided prior to exit. 2 the facility staff failed to ction A 1000. Race/Ethnicity Quarterly MDS (Minimum ent with an ARD (Assessment)		278			
	macular degeneration and arthritis.	on, gout, Alzheimer's disease, st recent MDS (minimum data		ANTIPO DE CONTRACTOR DE LA CONTRACTOR DE CONTRACTOR DE CONTRACTOR DE CONTRACTOR DE CONTRACTOR DE CONTRACTOR D			

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Event ID: K8DD11

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG	СОМ	(X3) DATE SURVEY COMPLETED C		
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,	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824				
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F 278	set) was a quarterly (assessment refere Resident #12 was a impaired for daily d review of this MDS Race/Ethnicity, Resident growth and the Resident was a sked about the wrong used as a guide to	y assessment with an ARD ence date) of 12/11/15. Coded as being severely ecision making. Further revealed in Section A1000 sident # 12 was coded as can American". If # 12's clinical record revealed the Resident's "Face Sheet" ras Caucasian. You 1/28/16 at 11:50 a.m. with ree) #2, an MDS Coordinator ent was reviewed. RN # 2 was scoded race in Section A and ring the MDS responded, "I just gone." When asked what is complete the MDS RN #2 e the RAI (Resident	F 2	78				
F 280 SS=D	ASM (Administrative Administrator, and a Consultant, these fill No further information of the survey. 483.20(d)(3), 483.1 PARTICIPATE PLA The resident has the incompetent or other incapacitated under	NNING CARE-REVISE CP e right, unless adjudged erwise found to be r the laws of the State, to ing care and treatment or	F 2	Corrective Action(s): Resident #11's comprehensive car have been reviewed and revised to the interventions and preventive recurrently in place to prevent falls. Management Incident & Accident was completed for this incident.	reflect neasures A Risk			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
AND PLAN O	F CORRECTION	DENTIFICATION NONDER.	A, BUILD	MNG	Antonomore de richi delle der demonstrate procurent de missi destinazión parte e della della della della della	1	С	
		495353	B. WING	Inches and the second		01/	/29/2016	
	PROVIDER OR SUPPLIER	NE		9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 S MAIN ST BLACKSTONE, VA 23824		·	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 280	A comprehensive of within 7 days after comprehensive assinterdisciplinary teat physician, a register for the resident, and disciplines as deterand, to the extent of the resident, the relegal representative and revised by a teach assessment.	are plan must be developed the completion of the sessment; prepared by an arm, that includes the attending ered nurse with responsibility d other appropriate staff in mined by the resident's needs, practicable, the participation of sident's family or the resident's e; and periodically reviewed earn of qualified persons after	F.	280	have been reviewed and revised to rethe interventions in place for wound and treatment for a new pressure we noted. A Risk Management Incident Accident Form was completed for the incident. Identification of Deficient Practic & Corrective Action(s): Any/all residents who have had a far have a wound may have potentially affected. A 100% review of their comprehensive care plans will be conducted by the RCC and/or design identify residents at risk. Residents identified at risk will be corrected a of discovery and a Risk Manageme	eflect care bund t & his es Il or been nee to		
	by: Based on staff into and clinical record the facility staff fail comprehensive ca in the survey samp 1. The facility staff Resident #11's corfollowing a fall on a comprehensive ca "Skin integrity," aft 12/28/15 for Resident #11 was 6/15/15 with diagn limited to: muscle	failed to review and revise the are plan under the care area er a wound was discovered on ent #7.			Incident & Accident Form will be completed for each incident identification. Systemic Changes: The assessment process will continue utilized as the primary tool for developing comprehensive plans of The RCC is responsible for implementation. The RAI Process. The nursing assest process as evidenced by the 24 Houng Report and documentation in the more record/physician orders will be used evelop and revise comprehensive of care. The Regional Nurse Consumund/or RCC will provide in-service training to the interdisciplinary care team on the mandate to develop individualized care plans within 7 of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated any changes in condition.	ed. care. enting sment ars edical d to plans ltant e plan days of		

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Facility ID: VA0108

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	<u> </u>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVE COMPLETED		URVEY ETED
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CEACH DEE	ICIENC'	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	1	(X5) COMPLETION DATE
#11's most requarterly ass reference dar cognitive skill severely imparent the prior asset Review of Rea nurse's not "At 1130 resis the day room the back of h (sic) w/c who w/c" Resident #1' problem ons information to reviewed or the seconducted with the fall we must update the complete	nd love ecent I essent to of las for l	w blood pressure. Resident MDS (minimum data set), a ent with an ARD (assessment 12/24/15, coded the resident's daily decision making as being Section J documented not sustained any falls since ent. It #11's clinical record revealed ed 7/14/15 that documented, sitting in his w/c (wheel chair) in sident tipped his w/c backwards ad was on another residents antitippers (sic) ordered for mprehensive care plan with a e of 6/18/15 failed to document ect the care plan had been d following the fall on 7/14/15. In p.m., an interview was a light of the who was responsible for plan). RN #2 stated, "For each a different intervention. We an for each intervention." RN provide evidence that Resident as reviewed and revised		280	Monitoring: The RCC and DON will be responder for maintaining compliance. The interdisciplinary team will audit a comprehensive care plans prior to finalization to monitor for compliany/all negative findings will be to the DON and RCC for immedicorrection. Detailed findings of the interdisciplinary team's audit will reported to the Quality Assurance Committee for review, analysis, a recommendations for change in policy, procedure, and/or practice. Completion Date: 3-14-1	ance. reported ate le be lind facility e.	d	

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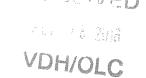
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CIA		(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		C	
		495353	B. WING			01/2	9/2016
	PROVIDER OR SUPPLIER SE HALL BLACKSTO	NE		90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST LACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 280	above findings. The facility policy ti documented in par condition must be a Assessment Coord resident's assessmented" No further information with the	age 35 tied, "Using the Care Plan" t, "5. Changes in the resident's reported to the MDS linator so that a review of the nent and care plan can be tion was presented prior to exit. was obtained from the website: h.gov/medlineplus/arrhythmia.h		280			
	comprehensive ca "Skin integrity," after 12/28/15 for Resident #7 was a and readmitted on included but not lirtype two diabetes, swallowing), sever and muscle weakr recent MDS (mining change assessme reference date) of coded as never unbeing understood Resident #7 was a impaired in the abit The resident was dependent on staff	failed to review and revise the are plan under the care area er a wound was discovered on ent #7. dmitted to the facility on 8/4/15 12/11/15 with diagnoses that nited to high blood pressure, stroke, dysphagia (difficulty e peripheral vascular disease ness. Resident #7's most num data set) was a significant nt with an ARD (assessment 12/18/15. The resident was derstanding others and never by others for communication. Coded as being severely litty to make daily decisions. Coded as being totally f with transfers, dressing, ygiene and bathing.					

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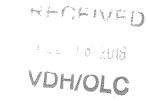
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 280	Review of Resident wound assessment report documented trype: Pressure, W. Malleolus, Wound wound identified: 1 Resident #7's care documented the for "Nursing Dx (diagnimpaired Problem Potential for skin b Goal and Target dasigns or healing (direview) Maintain in review. Approache ordered, turn and review. Approache ordered, air loss might preside measure and documented that intenskin integrity prior 12/28/15 pressure updated on the care of the uicer on 12/2 that the care plantidevelopment of the Review of the wourevealed an order documented the form of the strength of the 1/20 spray.** Review of the 1/20 spray.**	t #7's clinical record revealed a treport dated 12/28/15. This in part, the following: "Wound ound Location: Left Lateral Status: unchanged, Date 2/28/15" plan dated 12/18/15 sllowing: plan dated 12/18/15 sllowing: plan dated 12/18/15 sllowing: plan dated to incontinence. ate: Pressure ulcer will show ecrease in size) by next atact skin integrity thru next at the serior provide treatments as reposition resident q (every) 2 and heels while in bed, staff to ament on pressure areas as a tress to bed, cleanse each incontinent episode." at #7's care plan dated 12/18/15 and the development of the ulcer. Interventions were not re plan after the development 28/15. There was no evidence was reviewed after the		280		

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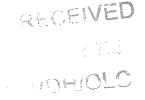
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	495353 NE	B. WING	STR	EET ADDRESS, CITY, STATE, ZIP CO S MAIN ST ACKSTONE, VA 23824		
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F 280	had been impleme On 1/28/16 at 4:45 conducted with LP the MDS (minimun asked the process stated, "We initiate is admitted to the f during any change When asked who care plan, LPN #1 communicate to M resident's condition appropriate interve asked the process a resident obtains "We get the treatm then we will write t care plan." LPN # plan and stated, "\ pressure in the go we had to be spec wounds." When s were put in place if pressure ulcer on I said I didn't know document every p she uses the RAI Instrument) manual the care plan. On 1/28/16 at 5:26 made aware of the information was p Facility policy titled documents the fol "4. Other facility	p.m., an interview was N (licensed practical nurse) #1, data set) coordinator. When of revising the care plan she a care plan when the resident actility and then we revise in the resident's condition." Is responsible for updating the stated that nursing will DS any changes in the n. MDS will then determine entions for that resident. When of updating the care plan after a pressure ulcer she stated, nent orders from the doctor and he wound and orders on the 1 reviewed Resident #7's care Well the care plan says all and target date; I didn't know iffic when identifying the hown that the interventions prior to the development of the 12/28/16, LPN #1 stated, "Like we had to be specific and ressure." LPN #1 stated that (Resident assessment all to help assist with completing above findings. No further rovided during survey. d. "Using the Care Plan," in particular to the particular to the particular to part		280			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	-		ONSTRUCTION		E SURVEY PLETED
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F 281 SS=D	Assessment Coord 5. Changes in the reported to the MD that a review of the care plan can be re 6. Documentation resident's care plan *Balsum Peru/Tryp that relieves pain a stimulates blood ve eschar and necroti obtained from http://dailymed.nlm ?setid=06ec7e77-2 483.20(k)(3)(i) SEI PROFESSIONAL The services provi must meet profess This REQUIREME by: Based on observat document review, facility staff failed to of practice for thre sample, (Resident 1. For Resident # develop an interim Resident's needs readmitted to the form	se supervisor and/or the MDS linator. resident's condition must be S Assessment Coordinator so resident's assessment and nade. must be consistent with the n." resin Spray: "Wound treatment and promotes healing; ressel activity and debrides to tissue." This information was n.nih.gov/dailymed/druglnfo.cfm 2fbf-4722-94d8-2c083a1759b3. RVICES PROVIDED MEET STANDARDS ded or arranged by the facility sional standards of quality. RNT is not met as evidenced ation, staff interview, facility and clinical record review, the to follow professional standards of 26 residents in the survey	F	281	F281 Corrective Action(s): Resident #4's attending physician been notified that the facility staff to develop and interim care plan for resident #4 after readmission. Resinow has a comprehensive care plan completed. A Facility Incident & Accident Form was completed for incident. Resident #6's attending physician been notified that the facility staff to accurately document the resider allergy to Bactrim. Resident #6's record and immunization records been updated to reflect the resider allergy to Bactrim. A Facility Incident Form was completed for incident.	failed or dent #4 n this has failed nt's clinical have nt's ident &	
			1 .		In Marca	untion shee	t Page 39 of 9

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	` ′сом	SURVEY PLETED
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F 281	sticker and immun Resident # 6's clin documented the R 3. Facility staff failthospital discharge Resident #7 received readers for Deceived The findings included. The findings included included, but were hypertension, hypodepression, glauced disease, coronary prostatic hypertropostatic hypertro	failed to ensure the allergy ization record contained in ical record accurately esident's allergy. ed to accurately transcribe orders dated 12/12/15 and yed unnecessary dressing mber 2015 and January 2016. de: as admitted to the facility on ed on 6/1/15 and again 6/16 with diagnoses that e not limited to: diabetes, erlipidemia, dementia, oma, gastroesophageal reflux artery disease, and benign only. est recent MDS (minimum datally assessment with an ARD erence Date) of 12/7/15. coded as an 8 out of a possible terview for Mental Status that the resident was ed. Section H "Bladder and ocumented that Resident # 4 and catheter & C. Ostomy my, ileostomy, colostomy). Conditions M0300" documented had "D. Stage 4: Full thickness ent # 4's clinical record revealed to the Resident's Face Sheet that		281	Resident #7's attending physician been notified that the facility staff to accurately transcribe the resident hospital discharge orders resulting unnecessary dressing changes. Res #7's physician orders have been re to ensure all medication and treatm orders are correctly written and transcribed. A Facility Incident & Accident Form was completed for incident. Identification of Deficient Practices/Corrective Action(s): All other residents may have been potentially affected. The DON, A and/or designee will conduct a 100 review of all resident medication attreatment orders, Allergies and car to include the presence of interim plans for new admissions to identifications at risk. All residents identifications at risk. All residents identifications at risk. All residents identification and an Incident & Accident form completed for each negative finding attending physician will be notificated incorrect medication order. Systemic Change(s): The facility policy and procedure been reviewed and no revisions at warranted at this time. The nursing assessment process as evidenced 24 Hours Report, documentation medical record and physician orderemains the source document for development and monitoring of the care which includes, obtaining, transcribing and administering phordered medications and treatmer revising and completing interimed to the resident and retarder revising and completing interimed the resident and retarder revising and completing interimed the resident and retarder revising and completing interimed the resident and resident and retarder revising and completing interimed the resident and recarded the resident and reason resident and r	failed t's in ident viewed nent this DON 19% and re plans, care fy any attified at scovery will be ng. The d of has re ng py the in the ers the ne plan ysician atts,	
	the Resident was	readmitted on 1/26/16 at 2:00	<u> </u>		Facility ID: VA0108 If conti	nuation she	et Page 40 of 9

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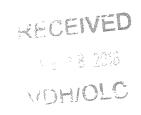
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The state of the s	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE	CONSTRUCTION	(X3) DATE :	SURVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	, .				
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		495353	B. WING			01/2	9/2016
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F 281	a.m.; further review 1/26/16 at 2:50 a.m (name of facility) fa Ambulance service and patent, drainin signs of bleeding manager	v revealed a nurse's note dated n., "Pt (patient) returned the acility at 2am transported by esFoley cath (catheter) intact g qs (quantity sufficient). No noted. Colostomy intact with no" It care plan book revealed that plan for Resident # 4. v on 1/28/16 at 1:45 p.m. with urse) # 6, the Unit Manager, a for Resident # 4's care plan. a "discharge folder" that plan with a date of 12/7/15. asked why the care plan was 6 stated that Resident # 4 tergency room on 1/25/16 and after midnight so he was admission and everything was atted that she was new but she was n	F 2	281	plans and accurate allergy alerts. Listaff will be inserviced by the DON and/or regional nurse consultant on procedure for obtaining and transcr physician medication & treatment or revising and completing interim car plans and ensuring that correct allerinformation is contained in the medication. Monitoring: The DON is responsible for maintal compliance. The DON, Unit Mana, and/or designee will performs char weekly coinciding with the care placalendar in order to maintain complexive findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of the audits will be reported to the Quali Assurance Committee quarterly for review, analysis, and recommendator change in facility policy, proceand/or practice. Completion Date: 3-14-16	the ibing orders, re regy lical lining ger t audits an liance.	
	During an intervie	w on 1/28/16 at 4:00 p.m. with	111		cility ID: VA0108 If contin	uation sheet	Page 41 of 99

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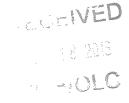
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
MIND LEVIN C			B. WING	***************************************		1	C 29/2016
		495353	a. WING		EET ADDRESS, CITY, STATE, ZIP CODE	017	LUILUIU
	PROVIDER OR SUPPLIER SE HALL BLACKSTO	NE		900	S MAIN ST ACKSTONE, VA 23824		
(X4) ID PREFIX TAG	JEACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 281	Continued From partial Administrator, and Consultant, these request for the facily request for the facily Plans—Preliminary plan immediate needs resident within two admission." According to "Fundamission." Accordin	age 41 ve Staff Member) # 1, the ASM # 3, the Regional Nurse findings were shared. A lity policy on interim care plans		281	DEFICIENCY		
	care the care of	ps ensure the continuity of an is developed on admission most significant problems and is					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	LETED
		495353	B. WING			1	9/2016
	PROVIDER OR SUPPLIER	NE		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST SLACKSTONE, VA 23824	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFINE DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 281	Continued From pareviewed and revis		F 2	281			
	sticker and immuni	failed to ensure the allergy ization record contained in cal record accurately esident's allergy.					
	10/23/14 with diagrant limited to: anxiet and high blood pre recent MDS (minimassessment with a date) of 10/22/15, cognitively intact (s	dmitted to the facility on moses that included but were ety disorder, muscle weakness ssure. Resident #6's most num data set), an annual in ARD (assessment reference coded the resident as being scoring a 15 out of a possible erview for Mental Status).					
·	nurse's note dated	at #6's clinical record revealed a 12/3/15 that documented, ractitioner) in and evaluated drash has spread to forehead new orders"					
	"Consult urologist	dated 12/3/15 documented, in AM to order new antibiotic. Bactrim- Allergic Reaction-					
	physician prior to 1 drug allergies; how recent physician's	mmaries signed by the 2/3/15 documented no known vever, Resident #6's most order summary signed by the 6 documented, "Allergies:					
	front cover of Resi	attached to the inside of the dent #6's clinical record rgic: NKA (No Known					

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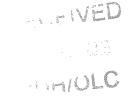
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				E SURVEY PLETED
		495353	B. WING			C 01/29/2016	
NAME OF	PROVIDER OR SUPPLIER	49333	D. 77 11 40	STREET ADDRESS, CITY, STATE, ZIP CO	ODF	U17.	29/2016
	BE HALL BLACKSTON	NE		900 S MAIN ST BLACKSTONE, VA 23824			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CONTROL INFORMATION	ID PREF TAG	PROVIDER'S PLAN OF COR IX (EACH CORRECTIVE ACTION	SHOULD	BE	(X5) COMPLETION DATE
F 281	"Allergies: NKDA (N Resident #6's comp problem onset date "Potential for injury. injury related to med next review. Approa as ordered by physical adverse side effects On 1/28/16 at 2:45 p conducted with RN stated a resident's at the label (RN #3 poil located in Resident immunization record sheet. When asked resident is newly dia #3 stated the allergy entered into the com (Medication Administ nurse's note. RN #3 are documented ever so you would have a allergy is newly diag be updated. On 1/28/16 at 5:52 p staff member) #1 (the (the director of nursi above findings. A poof allergies was requ	rehensive care plan with a of 10/31/14 documented, Goal & Target Date: Have no dication usage/side effects by aches: Administer medication cian; observe resident for any	F2	281			
		ation of allergies and stated					

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495353	B. WING		01	C /29/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	The same of the sa	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 281	Potter and Perry, Fedition, p. 843: "A To have qualified n medication history, No further informated as a second process of the seco	undamentals of Nursing, 6th client has the following rights: urses or physicians assess a including allergies." ion was presented prior to exit. failed to accurately transcribe orders dated 12/12/15 and Resident #7's clinical record #7 received unnecessary during December 2015 and dmitted to the facility on 8/4/15 12/11/15 with diagnoses that nited to high blood pressure, stroke, dysphagia (difficulty e peripheral vascular disease ess. Resident #7's most num data set) was a significant at with an ARD of 12/18/15. Reded as never understanding reing understood by others for esident #7 was coded as being in the ability to make daily sident was coded as being on staff with transfers, dressing,	F	281		

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	` сом	PLETED
MAD LEVIA O	y normalis de sourreur à l'eur y a	405053	B. WING			3	C 29/2016
	PROVIDER OR SUPPLIER			9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC	ix	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD RE	(X5) COMPLETION DATE
F 281	Further review of the September 2015 Record) that document by the Secretary with DWC apply 4X4 alleyon.	the clinical record revealed the FAR (Treatment Administration mented the following: "Cleanse apply Santyl* ointment and the following: This order	F	281			
	9/18/15 (the resolution Resident #7's clin went to the hospit	ve date of the wound). ical record revealed that she all on 12/6/15 for pneumonia. ed back to the facility on					
	1/15/16 revealed following: "Cleans	visician order sheet dated an order that documented the se sacral area with DWC, apply and, apply santyl, and allevyn QE order was discontinued on of survey.					
	TARS (treatment that Resident #7 treatment every of (the day the order	cember 2015 and January 2016 administration record) revealed had been receiving this day from 12/12/15 until 1/28/15 was discontinued).					
	une conducted	45 p.m., wound care observation Resident #7's skin on her ct. No wound or breakdown was a.					
	conducted with F unit manager. V wound order she somehow writter	21 p.m., an interview was RN (Registered Nurse) #6, the When asked about the sacral estated that the order was when the Resident returned cility on 12/12/15. When asked ble for transcribing hospital					46

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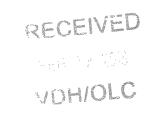
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		495353	B. WING		parame		29/2016
	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STA 900 S MAIN ST BLACKSTONE, VA 2382			
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCEI		BE	(X5) COMPLETION DATE
F 281	discharge orders sill so me." When aske hospital discharge order just came ove When asked the proshe stated that she on the discharge list ensure medications who is responsible orders on weekend "Our admissions or week when the sup asked if Resident # 9/18/15 (date of resident # 9/18/15)	nge 46 the stated," The unit managers, and if this order was on the orders she stated, "No. The er when it shouldn't have." Tocess of transcribing orders writes all the orders that are stand reviews the orders to are correct. When asked for transcribing admission as or night shifts she stated, anly come during the day and pervisors are here." When er had a sacral wound after solve date) she stated, "No. I ad happened; her bottom had	F2	281			
	of December 2015 Resident #7 could interview. On 1/28/15 at 4:30 made aware of the	ng on 3-11 shift for the month and January 2016 with not be reached for an p.m., administration was above concerns. No further esented during the time of					
	The facility policy ti	tled, "Physician Medication dress accurately transcribing					
	Nursing, Essentials (Potter and Perry, 2 used as a reference administration. A mount to administration.	mation is provided in Basic s for Practice, 6th edition 2007, pages 349-360) was e for medication redication order is required for my medication to a patient.					

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STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		NSTRUCTION	COMP	COMPLETED	
		495353	B. WING				9/2016	
	PROVIDER OR SUPPLIER SE HALL BLACKSTO	NE		900 S	T ADDRESS, CITY, STATE, ZIP CODE MAIN ST CKSTONE, VA 23824			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 281	place the physician complete order on form, the MAR. The name, room, and be names, dosages, find administration for extranscribing orders medications, dosage legible. The nurse and thoroughness, the same information by the nurse. It is accuracy of every patient with the patient.	It's or health care provider's the appropriate medication are MAR includes the patient's seed number, as well as the requencies, and routes of each medication. When each medication. When each medication when each checks all orders for accuracy when orders are transcribed, on needs to be checked again essential that you verify the medication you give to the citent's orders. To ensure safe stration, be aware of the six administration.	F2	281				
	directly to the wour necrotic (dead) tiss terminated when do complete and gran information was obout the complete and gran information was obtained and the complete and gran information was obtained from the complete and information was obtained from the complete and information the complete and grant information the complete and grant information was obtained and information the complete and grant information was obtained and information the complete and grant information was obtained and information the complete and grant information was obtained and information the complete and grant information was obtained and information the complete and grant information was obtained and information the complete and grant information was obtained and information the complete and information the com	n.nih.gov/dailymed/druglnfo.cfm 19ff-4338-a339-679a3f3f953d. Toof dressing that requires no coandage. Suitable for exuding with drainage). This information						



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CENTERS FOR MEDICARE & MEDICARD SERVICES		(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					C
		495353	B. WING				/29/2016
	ROVIDER OR SUPPLIER	NE		900	REET ADDRESS, CITY, STATE, ZIP CODE OS MAIN ST ACKSTONE, VA 23824	<u> </u>	
(X4) ID	CURANDVST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF		PROVIDER'S PLAN OF CORRE	OULD BE	(X5) COMPLETION DATE
PRÉFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APP DEFICIENCY)	10111111	
F 282 SS=D	The services provimust be provided accordance with e care. This REQUIREME by: Based on observinterview, facility or record review, it with staff failed to followers in the sum of the facility staff facere plan for asserving plan for asservi	ded or arranged by the facility by qualified persons in ach resident's written plan of ach resident's written plan of action, resident interview, staff locument review and clinical ras determined that the facility withe plan of care for one of 26 urvey sample, Resident #15. alled to consistently follow the essing the *bruit and *thrill of emodialysis **AV fistula on a during December 2015 and dible vascular sound associated of flow. Although usually heard ope, such sounds may be palpated as a thrill." This en from the website Im.nih.gov/books/NBK289/. s, a machine filters wastes, salt ur blood when your kidneys are renough to do this work riovenous (AV) fistula. A di AV fistula is a connection y and a vein, usually in the arm in. This is the preferred type of of effectiveness and safety." is taken from the website clinic.org/tests-procedures/hem	s	282	F282 Corrective Action(s): Resident #15's attending physic been notified that facility staff frassess the resident's Hemodialy shunt for Bruit and Thrill, bleed did not obtain pre and post dialysigns per plan of care. A facility and accident form has been conthis incident. Identification of Deficient Practices/Corrective Action(s All other residents who receive may have been potentially affe DON, ADON and/or designee conduct a 100% review of all receiving dialysis to identify risk for inconsistent/inapproprimonitoring. All residents iden risk will be corrected at time o and an Incident & Accident fo completed for each negative fi attending physician will be no each incident. Systemic Change(s): The facility policy and proceed dialysis care and management reviewed and no revisions are at this time. The DON and/or nurse consultant will inservice Licensed Nursing staff regard pre and post dialysis monitority reatment to be performed ever	sis AV ling and ysis vital y incident apleted for dialysis cted. The will esidents esidents at inte tified at f discovery rm will be anding. The tified of	
	dialysis/basics/re	esults/prc-20015015.					eet Page 49 0

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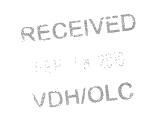
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495353	B. WING			01/	29/2016	
	PROVIDER OR SUPPLIER	NE		900	REET ADDRESS, CITY, STATE, ZIP CODE S MAIN ST ACKSTONE, VA 23824			
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F 282	The findings included Resident #15 was 1/7/15 with diagnose end stage kidney of diabetes. On the redata set), an annual assessment reference Resident #15 was impairment for mascored 13 out of 15 Mental Status (BIM as having received look back period. On 1/28/16 at 4:00 observed sitting in asked about her disched about her disched about her disched access site, she signame, and pointed of mid-way up her anstaff checks her at "Sometimes. Not staff takes her vita returns from her distance." "Same thin A review of the phy #15 revealed, in parestriction 1200 cooling to provide providers."	admitted to the facility on ses including, but not limited to: lisease, heart disease and most recent MDS (minimum al assessment with since date (ARD) 1/13/16, coded as having no cognitive king daily decisions, having 5 on the Brief Interview for 4S). Resident #15 was coded a dialysis services during the a p.m., Resident #15 was a chair in her room. When alysis three times a week. It would show the surveyor her nowed the surveyor her left but the AV fistula located m. When asked how often the coess site, she stated: usually." When asked if the lisigns when she initially inlysis appointments, she	F 2	882	Monitoring: The DON is responsible for mainta compliance. The DON, ADON, an Unit Manager will review docume on all residents who receive dialys weekly to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken an needed. Aggregate findings of the reviews will be reported to the Quassurance Committee quarterly for review, analysis, and recommendation for change in facility policy, proceand/or practice. Completion Date: 3-14-10	ntation is second		
	physician on 1/12/ not reveal any inst	16. A review of the orders did tructions related to the care of						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495353 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 50 the dialysis site or taking vital signs after the	(X3) DATE SURVEY COMPLETED C 01/29/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 50 the dialysis site or taking vital signs after the	01/29/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 50 the dialysis site or taking vital signs after the	DN (X5)
HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 50 the dialysis site or taking vital signs after the	N (X5)
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 50 F 282 the dialysis site or taking vital signs after the	N (X5)
(X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 50 the dialysis site or taking vital signs after the	N (X5)
the dialysis site or taking vital signs after the	D BE COMPLETIO
resident returned from dialysis.	
A review of the MARs (medication administration records) and TARs (treatment administration records) for Resident #15 for December 2015 and January 2016 revealed no evidence that the facility staff was assessing the resident's dialysis access site.	
A review of the nurses notes for Resident #15 revealed evidence that the staff assessed the bruit and thrill of the access site only on the following dates: 12/1/15 at 2:12 p.m.; 12/5/15 at 2:57 p.m.; 12/7/15 at 2:26 a.m.; 12/8/15 at 4:03 a.m.; 12/12/15 at 2:02 a.m.; 12/14/15 at 2:04 a.m.; 12/15/15 at 2:48 p.m.; 12/16/15 at 11:16 p.m.; 12/20/15 at 3:09 a.m. and 2:52 p.m.; 12/22/15 at 2:17 a.m.; 1/3/16 at 3:29 p.m.; 1/6/16	
at 4:48 p.m.; 1/8/16 at 2:28 a.m.; 1/14/16 at 2:52 a.m.; 1/15/16 at 10:04 p.m.; 1/16/16 at 2:57 a.m.; and 1/18/16 at 11:18 p.m. A review of the comprehensive care plan for Resident #15 dated 1/30/15 revealed, in part, the following: "Will receive dialysis as scheduled	
without complications through next reviewCheck left arm dialysis shunt before and after each dialysis treatment."	
On 1/29/16 at 8:50 a.m., LPN (licensed practical nurse) #3 was interviewed regarding care of residents receiving dialysis. She stated: "We usually have them on a fluid restriction. We have to check their dialysis site for bruits." When asked when the staff is to check the site for bruits, she stated: "When she comes back from dialysis." When asked where this assessment would be documented, she stated: "In the nurses	
L System State State System System System State	ation sheet Page 51 of CEIVED
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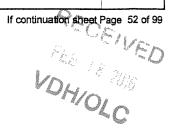
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		105050			remental de de la la la proprio de distribución presió discribión del como procurerporer		С
		495353	B. WING			01/	29/2016
	PROVIDER OR SUPPLIER GE HALL BLACKSTON	NE .		90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST ILACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
	Resident #15's care "No. I would have to "No. I would have to "No. I would have to "On 1/29/16 at 9:10 a manager for Resider regarding care of re She stated: "We do We get their vitals we dialysis." When ask documented, she st She further stated the thrill and bruit at resident returns from documentation also LPN #2 was shown TARs for Resident # January 2016. She assessments she had documented consist She stated: "No." Whad performed the adescribed, she state notes, then I would she had performed the facility, shall be to revealed, in part, the residents with ESRD including residents returned to staff includes, spe assessment data that resident's condition to basisThe care of g and training of staff in residents may be manager to the staff includes, spe assessment data that residents may be manager to the staff includes, spe assessment data that residents may be manager to the staff includes, spe assessment data that residents may be manager to the staff includes of these residents may be manager to the staff includes of these residents may be manager to the staff includes.	dif she was aware of what plan called for, she stated: to look it up." a.m., LPN #2, the unit stated: sidents receiving dialysis. cument intake and output. Then they return from the dwhere the vital signs are ated: "In the nurses notes." the access site when the dialysis. She stated this happens in the nurses notes. The nurses notes the nurses notes, MARs and the state of the access site when the access site when the find described were ently in the nurses notes. When asked if the facility staff is sessments she had die. "If it's not in the nurses say no." They policy entitled "End-Stage of a Resident With" of (End Stage Renal Disease), ecciving dialysis care outside rained in the care and special ents. Education and training staffically: The type of the state	F2	282			

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

Event ID: K8DD11

Facility ID: VA0108



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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL		(X3) DATE SURVEY COMPLETED			
AND PLAN C	F CORRECTION	HENTICATION NUMBER	A. BUILD	ING		С		
		495353	B. WING			01/3	29/2016	
	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		900	EET ADDRESS, CITY, STATE, ZIP CODE S MAIN ST ACKSTONE, VA 23824			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE	
F 282	A review of the faci Protocol" revealed assessment of resi services. A review of the faci Care Plan" revealed care plan shall be tresident's daily care to staff personnel with providing care or seresidentComplete resident's chart and at the appropriate resident's care On 1/26/16 at 9:50 #6 was interviewed residents receiving "We monitor vital sweights, scheduled When asked if she that would need to "Nope. That's it." was aware of what stated regarding the "No. I'd have to loce of 1/26/16 at 9:55	lity policy entitled "Dialysis no information related to dents receiving dialysis lity policy entitled "Using the d, in part, the following: "The used in developing the eroutines and will be available who have the responsibility for ervices to the ed care plans are placed in the d/or in a 3-ring binder located nurses 'ation must be consistent with plan." a.m., RN (registered nurse) regarding the care of dialysis services. She stated: igns, intake and outputs, I labs (laboratory tests)." could think of anything else be assessed, she stated: When she was asked if she Resident #15's care plan e dialysis care, she stated: ok to see."	F2	282				
	services. She state dialysis, we check to sure we document We also document When she was ask	of residents receiving dialysis ed: "When they get back from for thrill and bruit. We make on them in the nurses notes. on their fluid restriction." ed if she was aware of what e plan stated regarding the						

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Event ID: K8DD11

Facility ID: VA0108

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DESCRIPTION SHOULD BE COMPLETED COMPLETED (FACH CORRECTIVE ACTION SHOULD BE	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	in the dollar to do the t	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 53 STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE F 282 Continued From page 53 F 282	AND PLAN C)F CORRECTION	IDENTIFICATION NOMBER	A, BUILDI	NG	С	
HERITAGE HALL BLACKSTONE 900 S MAIN ST BLACKSTONE, VA 23824			495353	B. WING		01/29/2016	
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 282 Continued From page 53 F 282 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282			NE		900 S MAIN ST		
- January Company	PREFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFO	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETION	
On 1/26/16 at 10:00 a.m., ASM (administrative staff member) #1, the administrator, was informed of these concerns. No further information was provided prior to exit. Medical Surgical Nursing Made Incredibly Easy, Lippincott Williams & Wilkins copyright 2004, page 565, Dialysis Monitoring and Aftercare: "After completion of hemodialysis, monitor the vascular access site for bleeding. If bleeding is excessive, maintain pressure on the sited and notify the doctorTo prevent clotting or other problems with blood flow, make sure that the arm used for vascular access isn't used for any other procedure, including I.V. line insertion, blood pressure monitoring, and venipunctureAt least four times per day, assess circulation, blood pressure monitoring, and venipunctureAt least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site doe dialysis my indicated a blood clot requiring immediate surgical attention." F 309 HIGHEST WELL BEING 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, in accordance with the comprehensive assessment and plan of care.	F 309	dialysis care, she sign of the second and palpating four times per day, access site by auschruits and palpating circulatory assessment here. Lacess site doe dia requiring immediate 483.25 PROVIDE OHIGHEST WELL B Each resident must provide the necess or maintain the high mental, and psycholace of the second procedure with the control of the second palpating circulatory assessment here. Lacess site doe dia requiring immediate 483.25 PROVIDE OHIGHEST WELL B	tated: "Not right now." D a.m., ASM (administrative he administrator, was concerns. ion was provided prior to exit. ursing Made Incredibly Easy, & Wilkins copyright 2004, Monitoring and Aftercare: f hemodialysis, monitor the e for bleeding. If bleeding is a pressure on the sited and To prevent clotting or other d flow, make sure that the arm coess isn't used for any other g I.V. line insertion, blood g, and venipunctureAt least assess circulation at the cultating for the presence of g for thrills. Unlike most other nents, bruits and thrills should ack of a bruit at a venous alysis my indicated a blood clot e surgical attention." CARE/SERVICES FOR EING It receive and the facility must ary care and services to attain nest practicable physical, psocial well-being, in		F309 Corrective Action(s): Residents #15's attending physician value in the facility failed to followritten protocols and policies specific rendering the care of dialysis patients facility Incident and Accident form w	ow c for s. A	

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Event ID: K8DD11

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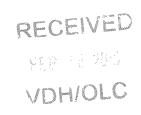
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1			COM	PLETED
							C
		495353	B. WING			01/	29/2016
NAME OF	PROVIDER OR SUPPLIER		L	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	FROVIDER OR SOLVEIER				00 S MAIN ST		
HERITA	SE HALL BLACKSTO	NE			LACKSTONE, VA 23824		
	CLUMATIN CTA	TEMENT OF DESIGNATES	ID		PROVIDER'S PLAN OF CORRECT	ION	(X5)
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F 309	by: Based on observa document review a was determined tha provide dialysis-rela residents in the sur The facility staff fail *bruit and *thrill of facility staff fail *TAV fistula, and to on the resident who on multiple occasion January 2016. **"A bruit is an audib with turbulent blood with the stethoscop occasionally also b information is taken http://www.ncbi.nlm **"In hemodialysis, and fluid from your no longer healthy e adequatelyArterio surgically created facility between an artery a you use less often. access because of This information is	tion, staff interview, facility and clinical record review, it at the facility staff failed to ated services for one of 26 vey sample, Resident #15. Ided to consistently assess the Resident #15's hemodialysis consistently obtain vital signs on she returned from dialysis ons during December 2015 and the vascular sound associated of flow. Although usually heard one, such sounds may be palpated as a thrill." This in from the website in.nih.gov/books/NBK289/. In a machine filters wastes, salts blood when your kidneys are shough to do this work ovenous (AV) fistula. A the very such as a connection and a vein, usually in the arm this is the preferred type of effectiveness and safety." taken from the website nic.org/tests-procedures/hemoults/prc-20015015.	F	309	Identification of Deficient Practices/Corrective Action(s): All other residents receiving dialysis have been potentially affected. The ADON, and Unit Managers will co 100% audit of all Dialysis residents physician orders and MAR's to ide residents at risk for not receiving physician ordered pre and post dial monitoring and communication fro dialysis center for all residents receiving dialysis. Residents identified at risk be corrected at time of discovery at comprehensive plans of care update reflect their resident specific needs attending physicians will be notified at risk be completed for each negative finding and a facility. Incident & Accident Form will be completed for each negative finding. Systemic Change(s): The facility policy and procedures been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced be 24 Hour Report and documentation medical record / physician orders the source document for the development of the provision of which includes, obtaining, transcriand completing physician medicat orders, treatment orders and the prost dialysis monitoring and communication. The DON and/or Regional nurse consultant will ins all licensed nursing staff on the process.	and both and	
	The indings includ	c .			for obtaining, transcribing, and	and	
	Resident #15 was a	admitted to the facility on			completing physician medication treatment orders. This inservice w	ill also	
	1/7/15 with diagnos	ses including, but not limited to:			include pre and post dialysis mon	toring	
	end stage kidnev d	isease, heart disease and			and communication per physician	orders.	
	dishetes On the m	nost recent MDS (minimum			and communication per payer		

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 (X4) ID PREFIX TAG CACH DEFICIENCY MUST BE PRECEDED BY FULL. REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 55 data set), an annual assessment with assessment reference date (ARD) 1/13/16, she assessment reference date (ARD) 1/13/16, she ADON and/or Unit Managers will audit		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	C C	
HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 55 data set), an annual assessment with assessment reference date (ARD) 1/13/16, she 900 s MAIN ST BLACKSTONE, VA 23824 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit			495353	B. WING	200000000000000000000000000000000000000		1	1
F 309 Continued From page 55 data set), an annual assessment with assessment reference date (ARD) 1/13/16, she ADON and/or Unit Managers will audit					90	00 S MAIN ST		
data set), an annual assessment with assessment reference date (ARD) 1/13/16, she The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will audit	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	DBE	COMPLETION
was coded as having no cognitive impairment for making daily decisions, having scored 13 out of 15 on the Brief Interview for Mental Status (BIMS). She was coded as having received dialysis services during the look back period. On 1/28/16 at 4:00 p.m., Resident #15 was observed sitting in a chair in her room. When asked about her dialysis services, she stated that she goes out to dialysis three times a week. When asked if she would show the surveyor her access site, she showed the surveyor her left arm, and pointed out the AV fistual located mid-way up her arm. When asked how often the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked if the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked of the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked of the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked of the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked how often the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked if the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked how often the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked how often the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. Not usually." When asked how often the staff takes her vital signs when she initially returns from her dialysis appointments, she stated: "Same thing. The staff takesh	F 309	data set), an annual assessment refere was coded as having making daily decising 15 on the Brief Interest (BIMS). She was codialysis services during a sked about her disched access site, she sharm, and pointed omid-way up her arrotaff checks her ac "Sometimes. Not a staff takes her vital returns from her distated: "Same thir A review of the phy #15 revealed, in parestriction 1200 cc Document in nurse (Monday Wedneso dialysis provider]." 3/18/15 and most aphysician on 1/12/1/15 not reveal any instate dialysis site or resident returned for the respresence of a document. The document in the top left.	al assessment with ance date (ARD) 1/13/16, she ing no cognitive impairment for ions, having scored 13 out of erview for Mental Status coded as having received uring the look back period. I. p.m., Resident #15 was a chair in her room. When ialysis services, she stated that alysis three times a week. I. would show the surveyor her nowed the surveyor her nowed the surveyor her hout the AV fistula located im. When asked how often the coess site, she stated: usually." When asked if the I signs when she initially ialysis appointments, she ing. Not usually." I. wsician's orders for Resident art, the following: "Fluid (cubic centimeters)/day - is notesDialysis MWF day Friday) at [name of local These orders were written recently signed by the 16. A review of the orders did ructions related to the care of taking vital signs after the form dialysis. Isident's chart revealed the ument taped to the front of the ent contained the resident's ft corner and was entitled	F3	809	The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will aud all dialysis residents Pre and Post dialy monitoring and communication weekly monitor for compliance. Any/all negating findings and or errors will be corrected time of discovery and disciplinary activity will be taken as needed. Aggregate findings of these audits will be reported the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	y to ive d at on	

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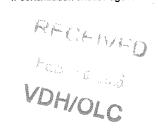
STATEMENT OF DEFICIEN AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495353	B. WING			01/	29/2016	
NAME OF PROVIDER OR HERITAGE HALL BL		NE		900	REET ADDRESS, CITY, STATE, ZIP CODE O S MAIN ST ACKSTONE, VA 23824			
PREFIX (EACH	DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	N SHOULD BE COMPLETION DATE				
"When the his access (blood pre resume ac access sit MD and the information hear the base of the proof of the	nent rever patient resident resident resident resident resident redialysis in in the nation." If the MAF and TARs or Residency 2016 residence to the nursidence to the residence to the residenc	aled, in part, the following: eturns from dialysis, assess bleeding and make sure his bp stable before letting him issess the thrill and bruit of the lift. If they're absent, notify the inurse and document this urses 'notes. (Feel the thrill, and surses 'notes. (Feel the thrill, and the staff administration (treatment administration (treatment administration (treatment administration and #15 for December 2015 evealed no evidence that the interest and the staff assessed the inaccess site only on the 1/1/15 at 2:12 p.m.; 12/5/15 at at 2:26 a.m.; 12/14/15 at 2:04 48 p.m.; 12/16/15 at 11:16 09 a.m. and 2:52 p.m.; n.; 1/3/16 at 3:29 p.m.; 1/6/16 at 2:28 a.m.; 1/14/16 at 2:52 0.4 p.m.; 1/16/16 at 2:57 a.m.;	F3	809				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED C		
	:	495353	B. WING	***********		I	29/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)				(X5) COMPLETION DATE
F 309	Resident #15 dated following: "Will recowithout complication reviewCheck left after each dialysis to the complex of the com	I 1/30/15 revealed, in part, the eive dialysis as scheduled ins through next arm dialysis shunt before and reatment." a.m., LPN (licensed practical viewed regarding care of dialysis. She stated: "We on a fluid restriction. We have sis site for bruits." When if is to check the site for "When she comes back from ked where this assessment end, she stated: "In the nurses a.m., LPN #2, the unit ent #15, was interviewed isidents receiving dialysis. In the stated: "In the nurses are tated: "In the nurses notes." In the nurses notes." In the access site when the m dialysis. She stated this happens in the nurses notes. The nurses notes, MARs and was asked if the	F3	809			

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NAME OF PROVIDER OR SUPPLIER 495353 NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY FULL TAG TAG CONTINUED FROM INST BE PRECEDED BY FULL TAG CONTINUED FROM INST BE PRECEDED BY FULL TAG F 309 Continued From page 58 it is. I will have to check." LPN #2 returned to the surveyor at 9.25 a.m. and stated: "The assistant director of nursing) lad just printed it off. it is not our protocol." When asked where the document originated, she stated: "The assistant director of nursing) lust printed it off." When asked why it contained the resident's chart, she stated: "It's not there anymore." LPN #2 was asked to provide the surveyor with facility policies and procedures regarding dialysis care. A review of the facility policy entitled "End-Stage Renal Disease), including residents receiving dialysis care outside the facility, shell be trained in the care and special needs of these residents. Education and training of staff includes, specifically. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basisThe care of grafts and fistulasEducation and training in ESRD and dialysis care. A review of the facility policy entitled "Dialysis Protocol" revealed in information related to assessment of residents receiving dialysis care. A review of the facility policy entitled "Dialysis Protocol" revealed in information related to assessment of residents receiving dialysis services. On 1/28/16 at 9:45 a.m., LPN #2 was asked to provide evidence of education provided to staff reparding the care and special needs of residents.	CENTRAL OF DECICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE SURVEY		
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BLACKSTONE, VA 23824 CAJID SUMMARY STIATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFEX TAG F 309 Continued From page 58 tis. I will have to check." LPN #2 returned to the surveyor at 9:25 a.m. and stated: "The assistant director of nursing] had just printed it off." When asked where the document originated, she stated: "The assistant director of nursing] just printed it off." When asked where the document originated, she stated: "The assistant director of nursing] just printed it off." When asked why it contained the resident's name and was taped to the front of the resident's cart, she stated: "It's not there anymore." LPN #2 was asked to provide the surveyor with facility policies and procedures regarding dialysis care. A review of the facility policy entitled "End-Stage Renal Disease, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically. The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basisThe care of grafts and fistulasEducation and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with special training in ESRD and dialysis care A review of the facility policy entitled "Dialysis Protocol" revealed no information related to assessment of residents receiving dialysis care A review of the facility policy entitled "Dialysis Protocol" revealed no information related to assessment of residents receiving dialysis care A review of the facility policy entitled "Dialysis Protocol" revealed no information related to assessment of residents receiving dialysis care and special needs of residents	NAME OF F	PROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE			
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG PROVIDERS PLAN OF CORRECTION PROVID	UEDITAC	E UALL BLACKSTOL	NE						
F 309 Continued From page 58 it is. I will have to check." LPN #2 returned to the surveyor at 9.25 a.m. and stated: "The assistant director of nursing] had just printed it off." It is not our protocol." When asked where the document originated, she stated: "The assistant director of nursing] had just printed it off." It is not our protocol." When asked where the document originated, she stated: "The assistant director of nursing] just printed it off." When asked why it contained the resident's name and was taped to the front of the resident's chart, she stated: "It's not there anymore." LPN #2 was asked to provide the surveyor with facility policles and procedures regarding dialysis care. A review of the facility policy entitled "End-Stage Renal Disease, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: The type of assessment data that is to be gathered about the resident's condition on a deily or per shift basisThe care of grafts and fistulasEducation and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with special training in ESRD and dialysis care A review of the facility policy entitled "Dialysis Protocol" revealed no information related to assessment of residents receiving dialysis services. On 1/26/16 at 9:45 a.m., LPN #2 was asked to provide evidence of education provided to traifing in ESRD and an advanced to the residents.	HERITAG	E HALL BLACKS FOR	11.		В				
it is. I will have to check." LPN #2 returned to the surveyor at 9:25 a.m. and stated: "[The assistant director of nursing] had just printed it off. It is not our protocol." When asked where the document originated, she stated: "[The assistant director of nursing] just printed it off." When asked why it contained the resident's name and was taped to the front of the resident's name and was taped to the front of the resident's chart, she stated: "It's not there anymore." LPN #2 was asked to provide the surveyor with facility policies and procedures regarding dialysis care. A review of the facility policy entitled "End-Stage Renal Disease, Care of a Resident With" revealed, in part, the following: "Staff caring for residents with ESRD (End Stage Renal Disease), including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. Education and training of staff includes, specifically: The type of assessment data that is to be gathered about the resident's condition on a daily or per shift basisThe care of grafts and fistulasEducation and training of staff in the care of ESRD/dialysis residents may be managed by the contracted dialysis facility or by a clinician with special training in ESRD and dialysis care" A review of the facility policy entitled "Dialysis Protocol" revealed no information related to assessment of residents receiving dialysis services. On 1/26/16 at 9:45 a.m., LPN #2 was asked to provide evidence of education provided to staff regarding the care and special needs of residents	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROPERTY.	D BE	COMPLETION	
receiving dialysis. She stated: "We don't have any evidence or inservices. But we will."	F 309	it is. I will have to a surveyor at 9:25 and director of nursing] our protocol." Whe originated, she stat nursing] just printed contained the reside the front of the resident there anymore. provide the surveyor procedures regarding the facility of the facility, shall be needs of these residents with ESR including residents the facility, shall be needs of these resident's condition basis The care of and training of staff residents may be medialysis facility or by training in ESRD and A review of the facil Protocol" revealed assessment of resiservices. On 1/26/16 at 9:45 provide evidence or regarding the care receiving dialysis.	check." LPN #2 returned to the m. and stated: "[The assistant had just printed it off. It is not a sked where the document red: "[The assistant director of dit off." When asked why it ent's name and was taped to dent's chart, she stated: "It's "LPN #2 was asked to or with facility policies and ng dialysis care. Itity policy entitled "End-Stage re of a Resident With" he following: "Staff caring for D (End Stage Renal Disease), receiving dialysis care outside trained in the care and special dents. Education and training pecifically: The type of the period of the period of the care of ESRD/dialysis had allowed by a clinician with special and dialysis care" It policy entitled "Dialysis no information related to dents receiving dialysis a.m., LPN #2 was asked to feducation provided to staff and special needs of residents She stated: "We don't have	F	309				

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Facility ID: VA0108

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY ETED
		495353	B. WING		01/29	/2016
	PROVIDER OR SUPPLIER GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	DDE	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 309	On 1/26/16 at 9:50 #6 was interviewed residents receiving "We monitor vital s weights, scheduled could think of anyth assessed, she stat asked if the facility regarding dialysis assessment, she s know from nursing On 1/26/16 at 9:55 regarding the care services. She state dialysis, we check sure we document When asked if the training regarding assessment, she services a	a.m., RN (registered nurse) I regarding the care of dialysis services. She stated: igns, intake and outputs, I labs." When asked if she ning else that would need to be led: "Nope. That's it." When had provided any training services and resident tated: "No. It's just what we school." a.m., RN #8 was interviewed of residents receiving dialysis led: "When they get back from for thrill and bruit. We make on them in the nurses notes. It on their fluid restriction." facility had provided any dialysis services and resident lated: "I do my own education ons online." 10 a.m., ASM (administrative the administrator, was concerns. 11 the service of hemodialysis, monitor the te for bleeding. If bleeding is in pressure on the sited and To prevent clotting or other of flow, make sure that the arm		309		
	used for vascular a procedure, includir	access isn't used for any other and I.V. line insertion, blood				

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Event ID: K8DD11

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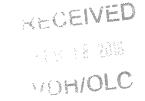
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 60 pressure monitoring, and venipunctureAt least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruit and thrills should be present here. Lack of a bruit at a venous access site doe dialysis my indicated a blood clot requiring immediate surgical attention." F 319 SS=D MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. F 319 STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 PROVIDERS PLAN OF CORRECTION (COMPRETED ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 F 309 F 309 F 319 STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 309 F 309 F 309 F 319 F 319 Corrective Action(s): Resident #9 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychosocial needs. His comprehensive care plan has been revised to reflect the current approaches and interventions in his plan of care.		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	IPLE CONSTRUCTION		E SURVEY PLETED
HERITAGE HALL BLACKSTONE (X4) ID PREFIX TAG CONTINUED FROM PROPERTY OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 60 pressure monitoring, and venipuncture At least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site doe dialysis my indicated a blood clot requiring immediate surgical attention." F 319 SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. F 319 SS=D SOB SMAIN ST BLACKSTONE, VA 23824 PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PROVIDERS PROVIDERS			495353	B. WING		ì	
F 309 Continued From page 60 pressure monitoring, and venipunctureAt least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site doe dialysis my indicated a blood clot requiring immediate surgical attention." F 319 SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. F 309 F 309 F 309 F 309 F 309 F 319 Corrective Action(s): Resident #9 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychosocial needs. His comprehensive care plan has been revised to reflect the current approaches and interventions in his plan of care.			NE		900 S MAIN ST		
pressure monitoring, and venipunctureAt least four times per day, assess circulation at the access site by auscultating for the presence of bruits and palpating for thrills. Unlike most other circulatory assessments, bruits and thrills should be present here. Lack of a bruit at a venous access site doe dialysis my indicated a blood clot requiring immediate surgical attention." F 319 SS=D Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. F 319 F 319 Corrective Action(s): Resident #9 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychosocial needs. His comprehensive care plan has been revised to reflect the current approaches and interventions in his plan of care.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	.D BE	(X5) COMPLETION DATE
by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide services to meet the psychosocial needs of two of 26 residents in the survey sample, Residents #9 and #14. 1. The facility staff failed to provide a psychological consult for Resident #9 as ordered by the physician. 2. The facility staff failed to follow-up on further psychological services recommended by a provider for Resident #14. The findings include: 1. Resident #14 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychosocial needs. His comprehensive care plan has been revised to reflect the current approaches and interventions in his plan of care. Resident #14 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychosocial needs. His comprehensive care plan has been revised to reflect the current approaches and interventions in his plan of care. The facility staff failed to follow-up on further psychological services recommended by a provider for Resident #14. The findings include: 1. Resident #14 has been assessed by the psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychologists and attending physician to assess his current needs and behaviors to establish an appropriate plan of treatment to meet his psychologists and terroit plan of treatment to meet his psychologists and terroit plan of treatment to meet his psychologists and terroit plan of treatment to meet his psychologists and treatment to meet his psychologists and terroit plan of treatment to meet his psychologists and terroit plan of treatment to m	F 319	pressure monitoring four times per day, access site by auso bruits and palpating circulatory assessing be present here. Laccess site doe dia requiring immediate 483.25(f)(1) TX/SV MENTAL/PSYCHO Based on the compresident, the facility who displays mental difficulty receives a services to correct. This REQUIREMED by: Based on staff intered and clinical record the facility staff falled the psychosocial net the survey sample, 1. The facility staff psychological consists by the physician. 2. The facility staff psychological services for Resided The findings including the survey sample, The facility staff psychological services for Resided The findings including the survey sample,	g, and venipunctureAt least assess circulation at the cultating for the presence of g for thrills. Unlike most other nents, bruits and thrills should ack of a bruit at a venous alysis my indicated a blood clot e surgical attention." C FOR SOCIAL DIFFICULTIES orehensive assessment of a must ensure that a resident all or psychosocial adjustment appropriate treatment and the assessed problem. NT is not met as evidenced erview, facility document review review, it was determined that and the determined that and the services to meet end of two of 26 residents in Residents #9 and #14. If failed to provide a ault for Resident #9 as ordered and failed to follow-up on further ces recommended by a sent #14. The second of the facility on admitted to the facility on a sent #14.		Corrective Action(s): Resident #9 has been assessed by the psychologists and attending physicial assess his current needs and behavior establish an appropriate plan of treat to meet his psychosocial needs. His comprehensive care plan has been reto reflect the current approaches and interventions in his plan of care. Resident #14 has been assessed by the psychologists and attending physicial assess his current needs and behavior establish an appropriate plan of treat to meet his psychosocial needs. His comprehensive care plan has been reto reflect the current approaches and	un to ors to ment evised he an to ors to tment evised	

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Facility ID: VA0108

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			01/29/2016
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST	Ē
		BLACKSTONE, VA 23824	OTION (VO)
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
to: history of a stroke with paralysis on one side of his body, dementia, psychosis, and major depression. On the most recent MDS (minimulata set), a significant change assessment with assessment reference date (ARD) 10/28/15, he was coded as being moderately impaired for making daily decisions, having scored eight outen on the BIMS (brief interview for mental state he was coded as having demonstrated exit-seeking behaviors during the look back period. A review of the clinical record for Resident #9 revealed the following physician's order, writte 4/1/15: [Name of mental health services provider] to eval (evaluate) and treat." Further review of the clinical record revealed in evidence that this order had been followed. On 1/28/16 at 9:20 a.m., ASM (administrative staff member) #1, the administrator, was aske provide the surveyor with evidence of all psychological/mental health consults for Resident #9. On 1/28/16 at 1:20 p.m., OSM (other staff member) #3, the social worker, approached the surveyor and gave her a copy of a document with the above-referenced mental health services provider's letterhead. The document was date 1/28/16. Review of this document revealed, in part, the following: "To Whom It May Concern On April 24, 2015, we received a referral from [name of facility] to see [Resident #9] for Ment Health Services. Our Intake Department determined this patient was not eligible for our service due to not having Medicare Part B." T document was signed by an executive vice	m h e t of us. o d to ent e vith d	Identification of Deficient Practic Corrective Action(s): All other residents who display psychosocial needs/difficulties may been potentially affected. The DO ADON or Unit Managers will con 100% review of all residents receipsychiatric treatment and follow undentify residents at risk. Resident identified at risk will have their cuneeds and behaviors assessed by the attending physician and/or psychic establish appropriate treatment interventions. An incident & accide form will be completed for each in the Systemic Change(s): The facility policy and procedure been reviewed and no changes are warranted at this time. The DON, Managers and/or RCC will review hour report daily to insure that earesident's current medical needs it their psychosocial needs are being addressed in a timely manner to ethat appropriate medical and psychological interventions are be obtained as ordered. All negative will be reported to administrator immediate corrective action. Monitoring: The Director of Nursing is respormaintaining compliance. The DO ADON and/or Unit Managers wiperform chart audits weekly coin with the Care Plan calendar to me compliance. Detailed findings of audits will be reported to the Quantum Assurance Committee for review analysis, and recommendations for the process of the pr	ay have N, duct ving up to ts urrent heir atrist to dent ncident. has e Unit v the 24- ch including g ensure eing findings for nsible for N, ll ciding onitor for the ality v,

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CTATEMENT	OF DECICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPL	E CONSTRUCTION	(X3) DATI	E SURVEY
	FOF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	, ,			COM	PLETED
							C
		495353	B. WING	Name of the	and a state of the	01/2	29/2016
NAME OF	PROVIDER OR SUPPLIER	I was a second		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
		L g pm		9	00 S MAIN ST		
HERITA	GE HALL BLACKSTO	NE		В	LACKSTONE, VA 23824		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 319	president of the me OSM #3 stated: "T they do not accept what the facility state another mental heat Resident #9, OSM ever put him on the psychologist who coosm #3 stated: "I (2015). They did not be needed anything is to make sure resident services, she follow up and make put him on the list." A review of the come Resident #9 dated revealed, in part, the by facility staff per fand physician order.	ental health services company. hey did not see him because his insurance." When asked ff had done to arrange for alth services provider for #3 stated: "I don't believe they allst to be seen by the omes here to see residents." only started here July first of communicate with me that g." When asked whose job it idents receive needed mental a stated: "I guess it's my job to a sure it's done. I'll have them aprehensive care plan for 10/7/11 and updated 10/28/15, the following: "Continued care PCP (primary care physician)	F	319	change in facility policy, procedure, and/or practice. Completion Date: 3-14-16		
	staff member) #1, t director of nursing, consultant, and RN nursing, were inform Policies and proced services were required. On 1/29/16 at 8:10 don't have that kind description for the significant discription for the signi	a.m., ASM #1 stated: "We lof policy. We do have a job social worker." A review of the Social Services Director" e following: "The Social lans, organizes, and directs tate the social, psychological,					

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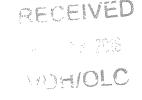
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY MPLETED
		495353	B. WING	i		1	C /29/2016
NAME OF	PROVIDER OR SUPPLIER		I	ST	REET ADDRESS, CITY, STATE, ZIP COD		
HERITA	SE HALL BLACKSTO	NE			0 S MAIN ST LACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 319	residentAssume residents to social, agencies. Docume records."	age 63 responsibility for referral of health, and community ent referrals in resident lon was provided prior to exit.	F	319			
	2. Resident #14 wa 7/15/14 and most r with diagnoses Incl *Asperger syndrom diabetes. On the mange assessmer #14 was coded as the BIMS. He was thinking, as having toward others during A review of the phy #14 revealed the for "Name of mental here"	as admitted to the facility on eccently readmitted on 12/21/15 udling, but not limited to: i.e., **schizophrenia and nost recent MDS, a significant in with ARD 12/28/15, Resident having scored 15 out of 15 on coded as having disorganized verbal behaviors directed ing the look-back period. sician's orders for Resident ollowing order written 12/21/15: i.e.alth services provider] to eval					
	Further review of the consult note from the provider dated 7/23 revealed, in part, the PLAN: Problem: Durefuses meds (mediate therapyOffer PsychologyDischameds but is willing very gregarious (tal.) On 1/28/16 at 1:20	t for behavioral health the clinical record revealed a the mental health service 15/15. A review of this note the following: "TREATMENT epression. Plan: Pt (patient) dications) but is willing to get therapy services/refer to arge from my clinic as refusing to get psychotherapy and is likative)." p.m., OSM (other staff pocial worker, was interviewed)					

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STATEMENT OF DEFICIENCIES AND PLANOT CONFECTION ADJUDING A SULDING B STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 BLACKSTONE, VA 23824 BLACKSTONE, VA 23824 F 319 PREFX A PROVIDER'S PLANOT CONNECTION CROSS-REFERENCES TO THE APPROPRIANE DEFICIENCY TAG PREFX TAG PROVIDER'S PLANOT CONNECTION CROSS-REFERENCES TO THE APPROPRIANE DEFICIENCY A PROVIDER'S PLANOT CONNECTION CROSS-REFERENCES TO THE APPROPRIANE DEFICIENCY TAG PREFX TAG PROVIDER'S PLANOT CONNECTION CROSS-REFERENCES TO THE APPROPRIANE DEFICIENCY TAG PREFX TAG PROVIDER'S PLANOT CONNECTION PREFX TAG PREFX TAG PROVIDER'S PLANOT CONNECTION PREFX TAG PREFX TAG PROVIDER'S PLANOT CONNECTION PREFX TAG PROVIDER'S PLAN				(200) A R II	710	T CONCTUICTION	(XX) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE CAJ ID SUMMARY STATEMENT OF DEFICIENCES STREET ADDRESS, CITY, STATE, ZIP CODE 900 \$ MAIN \$T\$ BLACKSTONE, VA 23824 CAGN DEFICIENCY MAIN TO REPRESENCE BY TALL 17M2 F319 COntinued From page 64 psychotherapy to Resident #14. She stated: "I just missed it." When asked what the process is for providing residents with psychotherapy as recommended by providers, she stated: "I receive the notes from [name of evaluating agency]. Then I give a copy to the unit and I keep a copy to follow up on. I just missed this, I guess I need to put him on the list for [name of psychologist who providers services at the facility]. "She explained that the provider who recommended the further therapy for Resident #14 don't does evaluations remotely: that is, the evaluation is not on facility property and the evaluation is one long-distance via computer technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. "Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '				
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE (X4) ID (RAD BLACKSTONE) (X4) ID (REGULATORY OR ISC IDENTIFYING INFORMATION) F 319 Continued From page 64 psychotherapy as recommended by providers, she stated: "I just missed It." When asked what the process is for providing residents with psychotherapy as recommended by providers, she stated: "I receive the notes from [name of evaluating agency). Then I give a copy to finame of evaluating agency). Then I give a copy to the unit and I keep a copy to follow up on. I just missed this. I guess I need to put him on the list for [name of psychologist who provides services at the facility)." She explained that the provider who recommended the further therapy for Resident #14 only dose evaluations remothely—that is, the evaluation is done long-distance via computer technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. ""Asperger syndrome (AS) is a developmental disorder, it is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website				A. BOILL	лис			
HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG) FREETX (EACH DEPICIENCY MUST BE PRECEDED BY FULL TAG) FROUNDERS PLAN OF CORRECTION (EACH OR CORRECTION PROFILE) FOR THE PROVIDERS PLAN OF CORRECTION ADMINISTRATION OF THE PREVIOUR DEPICIENCY (EACH CORRECTION ADMINISTRATION OF THE PREVIOUR DEPICIENCY) F 319 Continued From page 64 psychotherapy as recommended by providers, she stated: "I receive the notes from [name of evaluating agency]. Then I give a copy to the unit and I keep a copy to follow up on. I just missed tit. View asked what the provider who recommended the further therapy for Resident #14 only does evaluations remotely - that is, the evaluator is not on facility property and the evaluation is done long-distance via computer technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. ""Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website			495353	B. WING			01/2	29/2016
DEFINITION DEFINITION DEFICIENCIES DEACHSTONE, WA 23824	NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
(X4) D SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE OF THE PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE OF THE APPROPRIATE DEFICIENCY) F 319 Continued From page 64 psychotherapy for Resident #14. She stated: "I just missed it." When asked what the process is for providing residents with psychotherapy as recommended by providers, she stated: "I receive the notes from (name of evaluating agency). Then I give a copy to fellow up on. I just missed tils. I guess I need to put him on the list for (name of psychologist who provides services at the facility)." She explained that the provider who recommended the further therapy for Resident #14 only does evaluations remotely - that it, the evaluator is not on facility property and the evaluation is fone long-distance via computer technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. *"Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website		TUALL DI ACVETO	ME		1	900 S MAIN ST		
FREFIX TAG F 319 Continued From page 64 psychotherapy for Resident #14. She stated: "I just missed it." When asked what the process is for providing residents with psychotherapy as recommended by providers, she stated: "I receive the notes from (prame of evaluating agency). Then I give a copy to fellow up on. I just missed it." I guess I need to put him on the list for [name of psychologist who provides services at the facility]." She explained that the provider who recommended the further therapy for Resident #14 only does evaluations remotely - that it, the evaluator is not on facility property and the evaluation is done long-distance via computer technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. *"Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website	HERITAG	E HALL BLACKS TO	NE		1	BLACKSTONE, VA 23824		
psychotherapy for Resident #14. She stated: "I just missed It." When asked what the process is for providing residents with psychotherapy as recommended by providers, she stated: "I receive the notes from [name of evaluating agency]. Then I give a copy to the unit and I keep a copy to follow up on. I just missed this. I guess I need to put him on the list for [name of psychologist who provides services at the facility]." She explained that the provider who recommended the further therapy for Resident #14 only does evaluations remotely - that is, the evaluator is not on facility property and the evaluation is done long-distance via computer technology. She stated the evaluator and the resident are able to see each other and converse by way of computer screens. A review of the comprehensive care plan for Resident #14 dated 12/28/15 revealed, in part, the following: "Observe for changes in mental status. Provide consistent caregiver." On 1/28/16 at 5:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant, and RN #1, the assistant director of nursing, were informed of these concerns. ""Asperger syndrome (AS) is a developmental disorder. It is an autism spectrum disorder (ASD), one of a distinct group of neurological conditions characterized by a greater or lesser degree of impairment in language and communication skills, as well as repetitive or restrictive patterns of thought and behavior." This information is taken from the website	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
rger.htm.	F 319	psychotherapy for I just missed it." Wh for providing reside recommended by preceive the notes if agency]. Then I gives a copy to follow up I need to put him or psychologist who preceive the notes if agency]. The explain recommended the street was a commended to the street was a	Resident #14. She stated: "I ten asked what the process is ten asked what the provider asked this. I guess on the list for [name of rovides services at the ained that the provider who further therapy for Resident the unitions remotely - that is, the facility property and the long-distance via computer atted the evaluator and the esee each other and converse rescreens. In prehensive care plan for a 12/28/15 revealed, in part, therefor changes in mental ansistent caregiver. " p.m., ASM (administrative he administrator, ASM #2, the ASM #3, the regional nurse #1, the assistant director of med of these concerns. The (AS) is a developmental tism spectrum disorder (ASD), oup of neurological conditions greater or lesser degree of use and communication petitive or restrictive patterns avior." This information is site	Fí	319			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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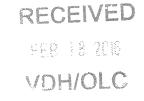
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE	CONSTRUCTION		SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILE	ING_		COM	
		495353	B. WING			1	29/2016
NAME OF I	ROVIDER OR SUPPLIER		L	ST	FREET ADDRESS, CITY, STATE, ZIP CODE		
LEDITAC	SE HALL BLACKSTO	NF			O S MAIN ST		
HERITAG	SE HALL BLACKS TO			В	LACKSTONE, VA 23824		
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F 319	Continued From pa **"Schizophrenia is that affects how a p This information is http://www.nimh.nil ophrenia-booklet-1 483.25(h) FREE O HAZARDS/SUPER The facility must er environment remai as is possible; and adequate supervisi prevent accidents. This REQUIREMED by: Based on observat documentation revifacility staff failed to on one of 4 units, 4 The facility staff failed to con one of 5 units, 4 The facility staff failed to on one of 5 units, 4 The facility staff failed to on one of 5 units, 4	age 65 a chronic and severe disorder person thinks, feels, and acts." taken from the website n.gov/health/publications/schiz 2-2015/index.shtml F ACCIDENT EVISION/DEVICES assure that the resident hazards each resident receives on and assistance devices to NT is not met as evidenced tion, staff interview, and facility it was determined that a maintain a safe environment to unit (secured unit). Ided to ensure that one of four its was secure. The janitor is East Secure Unit (400 unit) is unlocked. This closet is.	F:	3319		is erry inas (s) & ets view osets al r each	
	on 1/27/16 at 5:20 South East Secure	observation tour of the facility p.m. the janitor closet on the Unit (400 unit) was observed is closet had a key pad type			requirement to store external use ite separate in a locked compartment o closet.	ems	
····· · · · · · · · · · · · · · · · ·			ļ			des aphabatic Ve (R)	

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		TE SURVEY MPLETED C
		495353	B. WING			01	1/29/2016
	PROVIDER OR SUPPLIEF			900	REET ADDRESS, CITY, STATE, ZIP CO OS MAIN ST ACKSTONE, VA 23824		
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F 323	The following cher closet: High Performa Alkaline Bathr Antibacterial A Glass Cleanee Disinfectant C Bio-Enzymatio This observation v state inspector wh wandering the half door knobs. During an interview ASM (Administrator, this # 1 immediately so request for the Sa the unsecured che securing chemical During an interview LPN (Licensed Pronurse of the South closet was discussed in the Now that i left unlocked. LPM people wander are During an interview OSM (Other Staff the securing of the OSM # 7 stated, "are dangerous che	ance Neutral Floor Cleaner com Cleaner & Disinfectant All Purpose Cleaner com Cleaner & Cleaner com Cleaner & Cleaner com Clea	F	323	Monitoring: The Maintenance Director and Environmental Director are res for compliance. The Maintena Director and/or Environmental designee will perform daily rotensure there are no potential achazards related to chemical sto or Storage closets. All negative will be corrected at time of disa a Facility Incident and Accider completed for each incident. Rethe daily rounds will be review during the Risk Management of Meeting. Cumulative findings reported to the Quality Assurat Committee for review, analysis recommendations for change in policy, procedure, and/or pract Completion Date:	Director ands to recident rage areas e findings covery and at form esults of red weekly committee will be need, and an facility ice.	
Management and American Street	4. the Director of E	Environmental Services, the			** W/MM////WWW-formation/Address Address and other control or control of their season with a property of the control of the co		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED C
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	PROVIDER OR SUPPLIER GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZI 900 S MAIN ST BLACKSTONE, VA 23824	P CODE	
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F 323	unsecured janitor of 4 agreed that the cland further stated to opened without preserved. As stated earlier a Secure Unit was obtrying door knobs. as Resident # 17 in 1/27/16 at 2:25 p.m walking up and dovopen doors that we four times to open a state of times to open a state of the following as the facility of the facility shall be following: Under "Pin the facility shall be a state of the facility shall be a state of the facility shall be and the facility shall be a state of the facility shall be and the facility shall be a state of the facility shall be	closet was discussed. OSM # loset should have been locked that it could no longer be resing in the code. Resident on the South East reserved wandering around and This Resident was identified in the survey sample. On it is resident # 17 observed with hallways; attempting to re closed. The Resident tried an exit door to unit. admitted to the facility on itted on 1/20/15 with uded, but were not limited to: sion, hyperlipidemia, reflux disease, glaucoma, and e. Dest recent MDS (Minimum Data y assessment with an ARD rence Date) of 10/27/15. coded as being severely recision making. In Section E 900 Wandering - Presence & review of the service was coded as "3"	F3	323		

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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE SUMMAY STATEMENT OF DEPOPLICACES 900 S MAIN ST BLACKSTONE, NA 2382.4		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE COMF	PLETED
HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEFICIENCIES (FACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE) TAGE			495353	B. WING	- Andrewson (Control of Control o		1	- 1
Summary Statement of DeFiciencies Providers PLAN OF Correction (EACH DEFICIENCY MUST BE PRECEDED BY PLUI. TAG					90	00 S MAIN ST		
F 323 Continued From page 68 Interpretation and Implementation: 6. All chemicals used in all departments must (sic) stored in a secured area separate from non chemical (sic) items when not in use by staff." During an interview on 1/28/16 at 4:00 p.m. with ASM (Administrative Staff Member) # 1, the Administrator, and ASM # 3, the Regional Nurse Consultant, the unsecured janitor closet was shared. The SDS (safety data sheets) were reviewed and documented the following: - High Performance Neutral Floor Cleaner - Causes eye irritation. Harmful if inhaled Alkaline Bathroom Cleaner & Disinfectant - Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage Class Cleaner — Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage Glass Cleaner — Causes eye irritation Disinfectant Cleaner — Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage Glass Cleaner — Causes eye irritation Disinfectant Cleaner — Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage Glass Cleaner — Causes eye irritation Disinfectant Cleaner — Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage Glass Cleaner — Causes eye irritation Disinfectant Cleaner — Harmful if swallowed or in contact with skin. Causes severe skin burns and eye damage Risk Management Incident Report will be completed for each negative finding identified. Systemic Change(s): The facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dictician will inserved and no changes are warranted at this time. The consulting Registered Dictician will inserved and no changes are warranted at this time. The consulting Registered Dictician will inserved and no changes are warranted at this time. The consulting Registered Dictician will inserved and no changes are warranted at this time. The consulting Registered Dictician will inserved and no c	HERITAG	E HALL BLACKS TO	NE .		В			
Corrective Action(s): All dietary staff has been inserviced on the proper procedure for serving, preparing, distributing food in a way that is flavorful, platelle, attractive, and in the corrective and in the correction of selection. Identification of Deficient Practices & Corrective Action(s): All detary staff has been inserviced on the planned menus and indicated on the planned menus. Identification of Deficient Practices & Corrective Action(s): All other residents may have been potentia	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
and be followed.	F 363	Interpretation and Inchemicals used in a stored in a secured chemical (sic) items. During an interview ASM (Administrativ Administrator, and Aconsultant, the unshared. The SDS (safety dadocumented the following and interview Administrator). The SDS (safety dadocumented the following and interview Alkaline Bathro Harmful if swallowed Causes severe skinder and Alkaline Bathro Harmful if swallowed or in conskin burns and eye and Bourns and eye and Bourns and eye and eye damage. Bio-Enzymatic May cause an allowing and eye irritation 483.35(c) MENUS ADVANCE/FOLLOwing Menus must meet the residents in according dietary allowances Board of the Nation	mplementation: 6. All all departments must (sic) area separate from non s when not in use by staff." on 1/28/16 at 4:00 p.m. with e Staff Member) # 1, the ASM # 3, the Regional Nurse secured janitor closet was at a sheets) were reviewed and lowing: nce Neutral Floor Cleaner - n. Harmful if inhaled. on Cleaner & Disinfectant - ad or in contact with skin. In burns and eye damage. I Purpose Cleaner — Harmful if intact with skin. Causes severe damage. — Causes eye irritation. eaner — Harmful if swallowed kin. Causes severe skin burns Odor Eliminator Waterfall Mist ergic skin reaction. Causes in. MEET RES NEEDS/PREP IN WED the nutritional needs of ance with the recommended of the Food and Nutrition and Research Council, National			Corrective Action(s): All dietary staff has been inserviced the proper procedure for serving, preparing, distributing food in a way is flavorful, palatable, attractive, and the correct portion size and amounts indicated on the planned menus. An Incident & Accident form has been completed for this incident. Identification of Deficient Practice Corrective Action(s): All other residents may have been potentially affected. The CDM, and/Registered Dietician will monitor for portions and food servings during the meal passes for 3 days to identify an negative findings. All negative finding will be corrected at time of discover Risk Management Incident Report we completed for each negative finding identified. Systemic Change(s): The facility policy & procedure has reviewed and no changes are warranthis time. The consulting Registered Dietician will inservice the CDM and dietary staff on using the proper servutensils and preparing/serving food	that in as	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION		SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				СОМ	PLETED
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		495353	B. WING			01/:	29/2016
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
	- HALL DI ACKETO	NE .		9	00 S MAIN ST		
HERITAG	E HALL BLACKSTO	NE		В	BLACKSTONE, VA 23824		
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F 363	by: Based on observat of facility document ensure the planned needs of residents, followed. The ordered meat p not consistently pro The findings include Review of the resid from 11/17/15, 12/3 residents concern t portions had gotten On 1/27/16 at 5:00 dinner service tray t was pork to mien. T to take a serving of would pick pieces of place on the serving observed with varyi At times there did n the noodles. A few s greenish/brown bro noodles. At 6:05 p.t #3, the dietary man meat serving size w ounces." When ask determined in the lo	tion, staff interview, and review tation, the facility staff failed to Menu to meet the nutritional was properly prepared and cortions of three ounces were evided to the residents. e: ent council meeting minutes 80/15 and 1/26/16 documented that they thought the food a smaller. p.m. an observation of the line was made. The entree The dietary staff were observed a noodles with tongs and then of pork out of the noodles and g. Dinner plates were ng number of pieces of pork. Not appear to be any pork on small pieces of cooli were noted in the m. OSM (other staff member) ager, was asked what the was, OSM #3 stated, "Two sed how the meat portion was omien OSM #3 stated, "I can't at serving portion) because it's	F	363	Monitoring: The CDM is responsible for maintai compliance. The CDM will perform random meal preparation reviews we to monitor for compliance. The resu these reviews will be reported to the Quality Assurance Committee for reanalysis, & recommendations for chin facility policy, procedure, and/or practice. Completion Date: 3 - 14-16	eekly its of view,	
	An interview was co	onducted with OSM #3 on					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		PLETED
7 SETEM 1 BUTTET W		"	7. DOILD				
		495353	B. WING			01/2	29/2016
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HERITAG	SE HALL BLACKSTO	NE .		BL	ACKSTONE, VA 23824		
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F 363	1/28/16 at 8:10 a.m the required food p dietitian. I was wrothave been three out. An interview was ca a.m. with OSM #11 manager. When as knew what portions stated, It's on the amenu). It shows yo portions on it." Whethey were serving they were s	i. When asked who provided ortions OSM #3 stated, "The rig it (the meat portion) should inces not two ounces." Inducted on 1/28/16 at 9:05, the assistant dietary ked how the serving staff were to be served OSM #11 ddition form (the extended a exact servings and exact en asked how servers knew the correct amount of lo mien stated, We just realized it this server) did it wrong, she was three ounce utensil to get She stated that the meat and of supposed to be mixed in ad that it looked like there were	F3	363			
F 364 SS=E	pork lo mien with pleight ounces. On 1/28/16 at 5:30 member) #1, the addirector of nursing, findings. 483.35(d)(1)-(2) NUPALATABLE/PREFEACH resident receifed prepared by members.	ives and the facility provides nethods that conserve nutritive ppearance; and food that is	F3	364	F 364 Corrective Action(s): All dietary staff has been inserviced or the proper procedure for serving, preparing, distributing food in a way the is flavorful, palatable, attractive, and at the proper temperature. The RD and CDM have reviewed the Federal and S guidelines for preparing, distributing a	nat t	

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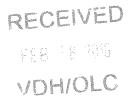
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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY MPLETED
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NAME OF	PROVIDER OR SUPPLIER			l	TREET ADDRESS, CITY, STATE, ZIP CODE		
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TILITA	JE HALL DEAGHOTO		₄	В	LACKSTONE, VA 23824		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 364	This REQUIREMED by: Based on observa	NT is not met as evidenced	F3	364	maintaining foods at the proper temperatures and to prepare and so food in a palatable and nutritive m	anner.	
	interview, facility do course of a compla determined that the and serve food in a manner.	ocument review and in the int investigation, it was a facility staff failed to prepare palatable and nutritive			Corrective Action(s): All other residents may have been potentially affected. The Administ CDM, and/or Registered Dietician randomly monitor and sample test all meals for the next 3 days prior	rator, will trays of to	
	was not palatable a ravioli and broccoli and pasty; steamed	ner on 1/27/16 at 6:30 p.m. and tasted as follows: pureed had little taste and were sticky d broccoli was a pale green chewing as it was so soft.			serving to identify any negative fir All negative findings will be corre time of discovery. A Risk Manage Incident Report will be completed each negative finding identified.	cted at ement	
	The findings include An anonymous con	nplaint received alleged that			Systemic Change(s): Current facility policy & procedur been reviewed and no changes are warranted at this time. The consu Registered Dietician will inservice	lting	
	Resident #6 was ac 10/23/14 with diagr not limited to: anxie and high blood pres recent MDS (minim assessment with a date) of 10/22/15, cognitively intact (s 15 on the Brief Inte (BIMS). On 1/27/10 was conducted with how the food at the stated, "Don't talk a she meant, Reside cooked the way she food was mostly ov	dmitted to the facility on moses that included but were sty disorder, muscle weakness assure. Resident #6's most num data set), an annual n ARD (assessment reference coded the resident as being coring a 15 out of a possible rview for Mental Status at 4:10 p.m. an interview no Resident #6. When asked facility tasted, Resident #6 about that." When asked what not #6 stated the food was not be preferred it cooked and the ercooked. On 1/27/16 at 5:35 was observed feeding herself-in-			CDM and dietary staff on the propagnitation, storage, cleaning and transportation of dietary products established policy and procedure. inservice will include preparing pand nutritive foods and maintaining and cold temperatures during measet up and delivery.	per The alatable ng hot	

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Event ID: K8DD11

Facility ID: VA0108

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MAME OF PROVIDER OR SUPPLIER		T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	COM	E SURVEY PLETED
HERITAGE HALL BLACKSTONE Main ST BLACKSTONE, VA 23824			495353	B. WING		i i	29/2016
F 364 Continued From page 72 her room. Observation of the resident's meal tray revealed the broccoli was dark green and mushy; the egg roll was dark brown and crisp. Resident #6 ate two bites of her broccoli and stated she ate all of the broccoli she could. A group interview was held on 1/28/16 at 2:30 p.m. with five residents who were cognitively intact. When asked about the food served, residents stated, "It's not worth a damn, taste or temperature; broccoli is overcooked." The residents also stated that the there is not enough variety, the food was not cooked well. The green beans were undercooked, the rolls were gummy, the combread was mushy and the seafood was of such low quality they should take it off the menu." Review of the resident council meeting minutes from 11/17/15, 12/30/15 and 1/26/16 documented residents did not like the eggs, the yeast rolls were undercooked and they would like to have a salad at least one time a day. On 1/27/16 at 5:00 p.m. the beginning of the dinner tray line service was observed by two surveyors. A test tray of food served was requested as the last food tray was being completed. Three surveyors followed the last food					900 S MAIN ST	IP CODE	
her room. Observation of the resident's meal tray revealed the broccoli was dark green and mushy; the egg roll was dark brown and crisp. Resident #8 ate two bites of her broccoli and stated she ate all of the broccoli she could. A group interview was held on 1/28/16 at 2:30 p.m. with five residents who were cognitively intact. When asked about the food served, residents stated, "It's not worth a damn, taste or temperature; broccoli is overcooked." The residents also stated that the there is not enough variety, the food was not cooked well. The green beans were undercooked, the rolls were gummy, the combread was mushy and the seafood was of such low quality they should take it off the menu." Review of the resident council meeting minutes from 11/17/15, 12/30/15 and 1/26/16 documented resident concerns that they thought the food portions had gotten smaller, the food was unhealthy such as too much gravy and grease. The residents did not like the eggs, the yeast rolls were undercooked and they would like to have a salad at least one time a day. On 1/27/16 at 5:00 p.m. the beginning of the dinner tray line service was observed by two surveyors. A test tray of food served was requested as the last food tray was being completed. Three surveyors followed the last food	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
On 1/27/16 at 5:00 p.m. the beginning of the dinner tray line service was observed by two surveyors. A test tray of food served was requested as the last food tray was being completed. Three surveyors followed the last food	F 364	her room. Observer revealed the broconthe egg roll was dated the broconthe egg roll was dated. The broconthe egg roll was determined to the broconthe egg roll was also stated. The residents also stated are under the combread was such low quality the Review of the resident concerns portions had gotted unhealthy such as The residents did not were undercooked.	ation of the resident's meal tray coli was dark green and mushy; ark brown and crisp. Resident her broccoli and stated she ate she could. was held on 1/28/16 at 2:30 dents who were cognitively dabout the food served, lt's not worth a damn, taste or coli is overcooked." The ed that the there is not enough as not cooked well. The green cooked, the rolls were gummy, a mushy and the seafood was of ey should take it off the menu." dent council meeting minutes 30/15 and 1/26/16 documented that they thought the food in smaller, the food was too much gravy and grease. In tike the eggs, the yeast rolls and they would like to have a	F3	The CDM is responsible for compliance. The Administ CDM will perform random samplings weekly to monit compliance. The results of will be reported to the Quadrecommittee for review, and recommendations for charpolicy, procedure, and/or	n test tray tor for these reviews ality Assurance alysis, & age in facility practice.	
cart and observed as the residents were being served from the cart. At 6:30 p.m. OSM #3, the dietary manager, assisted the three surveyors in tasting all the items on the tray. The pureed ravioli had a slight tomato taste and a pasty, sticky consistency. When asked what the ravioli tasted like OSM #3 stated, "It tastes like tomatoey thickener." When asked what the pureed broccoli		dinner tray line ser surveyors. A test tr requested as the la completed. Three cart and observed served from the ca dietary manager, a tasting all the items had a slight tomatic consistency. Wher like OSM #3 stated	rvice was observed by two ray of food served was ast food tray was being surveyors followed the last food as the residents were being art. At 6:30 p.m. OSM #3, the assisted the three surveyors in s on the tray. The pureed ravioli to taste and a pasty, sticky asked what the ravioli tasted d, "It tastes like tomatoey				

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Facility ID: VA0108

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STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353	B. WING	***************************************		_	9/2016
	ROVIDER OR SUPPLIER	NE		90	REET ADDRESS, CITY, STATE, ZIP CODE 0 S MAIN ST LACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 364 F 371 SS=F	thickener." The sur broccoli. The broccoli osmall bits. The both chewing. When as broccoli OSM #3 strengies well cooke was tasted by the costated, "I eat the foresidents voiced ar OSM #3 stated, "Warde improvement of the costated of the c	stated, "I can taste the veyors tasted the steamed coli was a very pale green and roccoli did not require ked about the texture of the tated, "The residents like the d." When asked if the food dietary manager OSM #3 od here everyday but I'm redinner." When asked if the my concerns about the food, then I first got here, yes. We've ts over time." onducted on 1/28/16 at 9:05, the assistant dietary sked if she routinely tasted the SM #11 stated that they did not pureed foods. OSM #11 stated if the food from the previous The ravioli tasted like ravioli ste. I didn't like the (pureed) need to season it." ROCURE, E/SERVE - SANITARY om sources approved or ctory by Federal, State or local distribute and serve food		371	F 371 Corrective Action(s): The CDM has reviewed the Federal a State guidelines for preparing, storing distributing food under sanitary conditions, as well as the policy and procedure for establishing a proper cleaning schedule, the proper storage clean dishware. All kitchen dishware equipment identified as dirty on the is kitchen tour were immediately re-was or cleaned. The Ice Machine has beer	of and nitial shed	
					completely emptied and sanitized price	JI 10	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	TIPLE	CONSTRUCTION	(X3) DATE SURVEY		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:					PLETED
		495353	B, WING	·		01/2) 29/2016
NAME OF	PROVIDER OR SUPPLIER	70000			REET ADDRESS, CITY, STATE, ZIP CODE	, , , , , ,	
					S MAIN ST		
HERITAC	SE HALL BLACKSTO	NE		BL	ACKSTONE, VA 23824		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	by: Based on observa document review, i facility staff failed to sanitary manner. Several pans were can opener blade, clean trays were al The findings includ On 1/27/16 at appr inspection of the ki following concerns 6 large cookie-shee 2 half-size cookie-snesting.	NT is not met as evidenced tion, staff interview, and facility t was determined that the prepare and serve food in a observed wet nesting, ovens, ice machine and a cart for lobserved to be dirty. e: oximately 11:25 a.m. the techen was conducted. The were identified: et style pans were wet nesting.	F	371	re-use. A facility Incident & Accide report has been completed for this incident. Identification of Deficient Practice Corrective Action(s): All other residents may have been potentially affected. The Administra CDM, and/or Registered Dietician we monitor the kitchen preparation area the cleaning of these areas during an after meals 3 times a week to identify negative findings. All negative finding will be corrected at time of discover facility Incident & Accident report we completed for each negative finding identified. All negative findings will result in appropriate disciplinary act Systemic Change(s): Current facility policy & procedure been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice to CDM and dietary staff on the proper sanitation, storage, cleaning and	tor, vill and d y any ngs y. A vill be	·
of large cookie-she was dirty with loose pans rested on, as debris on all aspect at the bottom level		cart/rack containing a supply set style pans on each level a debris in the tracks that the well as dried stuck-on food ts of the cart/rack. In addition, of this cart/rack was 3 of these pans that were dirty and had			transportation of dietary products per established policy and procedure. The inservice will include all aspects of infection & sanitation control measure appropriate cleaning and storing of dietary equipment.	ie	
	2 large metal mixin	g bowls and one large metal ked inverted and ready for o of these 3 bowls was own substance.				,	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING			MPLETED C
		495353	B. WING	ATTOC COLUMN STATES			/29/2016
	PROVIDER OR SUPPLIE			90	REET ADDRESS, CITY, STATE, ZIP COD 00 S MAIN ST LACKSTONE, VA 23824	E	
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 371	stuck-on debris. The 2 convection dirty with black ar them. Upon opening the and loose debris rim of the machin of debris was obsice machine lid at the ice. Inside the	olade was dirty with loose and ovens and a third oven were and brown dried-on debris inside elid to the ice machine, dried were observed along the lower served around the hinge of the and could potentially fall off into e machine on the face of the ice mount of black bulldup was		371	Monitoring: The CDM is responsible for mate compliance. The dietary audit to monitoring food preparation and as well as, sanitation/infection of the completed 3 times a week by Administrator and/or Food serving maintaining compliance. The resulting these audits will be reported to Quality Assurance Committee analysis, & recommendations for in facility policy, procedure, an practice. Completion Date: 3-14-1	ool for I storage, control will the ice and esults of the for review, or change d/or	
	items was discus Member) the diet each of these iter for use. When as he was not able to fa daily cleaning 11/18/15, 11/19/11/123/15, 11/24/11 and 1/20/16 - for month period) and weekly or deep-out A review of the puill be maintaine sanitary manner.						
	documented, "2. rinsed free of large be loosened by s	olicy for "Dishwashing" Dishes will be stacked and ge loose food particles. Dirt sha scrubbing the surface of the brush or an abrasive pad and	11				

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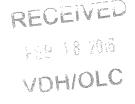
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TIPLE CONSTRUCTION	COI	TE SURVEY MPLETED
		495353	B. WING			/29/2016
	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 371	rinsing7. allow of completely before so on 1/28/16 at the elapproximately 5:30 #1 (Administrator), ASM RN #1 (Registered of Nursing), and ASC consultant) were mfurther information survey. According to the Feregulations: 4-601.11 Equipment Nonfood-Contact Social	ean dishes to air dry storing" and of day meeting at p.m., the ASM Corporate Staff, the M #2 (the Director of Nursing), Nurse, the Assistant Director SM #3 (the regional nurse ade aware of the findings. No was provided by the end of the ederal Food and Drug at, Food-Contact Surfaces, surfaces, and Utensils. food-contact surfaces and ean to sight and touch. Contact surfaces of cooking as shall be kept free of deposits and other soil contact surfaces of equipment of an accumulation of dust, dirt, other debris. at and Utensils, Air-Drying wed to drain and to air-dry end or stored. Stacking wet a prevents them from drying environment where an begin to grow. Cloth drying stensils is prohibited to preventer of microorganisms to	F3	5.71		

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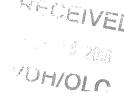
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495353	B. WING			-	9/2016	
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				90	00 S MAIN ST			
HERITAG	BE HALL BLACKSTO	NE .		В	LACKSTONE, VA 23824			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 372 F 372 SS=C	PROPERLY The facility must disproperly. This REQUIREMENT by: Based on observated document review, if facility staff failed to in a clean and sanith of the findings included on 1/28/16 at appropersion of the duwith OSM #4 (Othe Services Director). Noted. He pointed general trash and 2 the dietary dumpster white liquid dripping this liquid mixed with and/or melted show dumpster towards the tracked everyday by (environmental sendietary). On 1/28/16 at appropersion of the dietary manger) we regarding the dietary	SE GARBAGE & REFUSE spose of garbage and refuse NT is not met as evidenced tion, staff interview, and facility t was determined that the maintain the dumpster area tary manner to prevent pests.	F3	372	F-372 Corrective Action(s): The area around the dumpsters was cleaned of the trash on the ground and was properly disposed of inside the dumpsters. The ground around the dumpsters was power sprayed to eliminate associated residuals. Identification of Corrective Deficient Practice(s) & Corrective Action(s): All other garbage disposal areas have potential to be affected. The Maintent Director and Environmental Services Director will inspect all garbage storates areas to identify risk. Any/All negatifindings will be corrected at time of discovery. Systemic Change(s): The facility policy & procedure for the storage and disposal of refuse was reviewed and no changes are warrant this time. The Maintenance Director and/or Environmental Services direct will provide in-services to all staff of proper techniques for the collection, storage, and disposal of refuse. The inservice training will include dispose of all refuse inside supplied dumpste and keeping lids closed at all times.	the nance age ve		
	determine if the factorial stated nothing should be stated nothing should be stated as a second stated stated stated as a second stated state	ility could get a new one. He ald be leaking from it.	Approximate transfer or control of the control of t					
	1		1		1			

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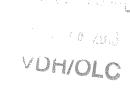
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COV	IPLETED C
		495353	B. WING		01	29/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 900 S MAIN ST BLACKSTONE, VA 23824	ZIP CODE	
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 372	A review of the pol and Refuse" documents containers leaks and covered On 1/28/16 at the approximately 5:3/#1(Administrative/Administrator), ASRN #1 (Registered for Nursing), and Aconsultant) were refurther information survey.	icy for "Disposal of Garbage mented, "1. Garbage and should be free from cracks or when not in use" end of day meeting at 0 p.m., the ASM Corporate Staff, the iM #2 (the Director of Nursing), d Nurse, the Assistant Director SM #3 (the regional nurse made aware of the findings. No was provided by the end of the DRUG RECORDS,		The Environmental Services responsible for maintain The Maintenance Direct Environmental Services complete rounds of dum to monitor and maintain refuse on the ground sur dumpsters will be correct The results of these roun reported to the Quality Committee for review, a recommendations for chapolicy, procedure, and/or Completion Date: 3-431	ing compliance. or and/or Director will spster areas daily compliance. Any rounding the cted immediately. ads will be Assurance analysis, & ange in facility or practice.	
SS=D	The facility must ea licensed pharma of records of rece controlled drugs in accurate reconcility records are in ord controlled drugs in reconciled. Drugs and biological labeled in accordance professional prince appropriate accessional controlled accessiona	employ or obtain the services of acist who establishes a system ipt and disposition of all a sufficient detail to enable an ation; and determines that drug for and that an account of all is maintained and periodically cals used in the facility must be ance with currently accepted siples, and include the asory and cautionary the expiration date when		Corrective Action(s): LPN #7 received discipl leaving medications una medication cart and has by the regional nurse correction Proper Medication Adm to include storing all me locked medication cart line of sight or in control Nursing staff. A facility accident report was contincident.	been inserviced on the been inserviced on sultant on the hinistration Policy edications in a when it is not in bl of the Licensed of incident &	
	In accordance with	th State and Federal laws, the all drugs and biologicals in ents under proper temperature mit only authorized personnel to be keys.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		SURVEY PLETED
		495353	B. WING 01/29/2			29/2016	
		480000	D. 11.10		TREET ADDRESS, CITY, STATE, ZIP CODE	0 1/2	29/2010
NAME OF I	PROVIDER OR SUPPLIER						i
HERITAC	SE HALL BLACKSTO	NE			00 S MAIN ST		l
I ILLIAN A	L IIALL DENOITO	· 		В	SLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	permanently affixed controlled drugs list Comprehensive Drugs Control Act of 1976 abuse, except when package drug distriquantity stored is more readily detected. This REQUIREMENT by: Based on observated documentation revised ility staff failed to 4 units; the 100 unit. The facility staff failed to 4 units; the 100 unit. The medication aunit. The medication cart unsof LPN (licensed project) in the findings included to 1/27/16 at 4:15 administration obset 4:36 p.m. on the 10 nurse) #7 prepared	ovide separately locked, of compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit ribution systems in which the ninimal and a missing dose can of the secure medications on one of the drugs and facility ewith was determined that the secure medications on one of the secure abottle of the secure determined that the secure and the secure of	F4	31	Identification of Deficient Practices Corrective Action(s): All unit Medication Carts used to store and dispense medications and narcotic during medication passes may have be potentially affected. The DON and/or designee will conduct a 100% review all licensed nurses during medication passes to identify any medication carts that are left unlocked or unattended during medication passes. Any/all negative findings will be corrected at to of discovery. A facility Incident and Accident form will be completed for expected incident identified. Systemic Change(s): Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed number incident incident policy and procedure for storing medications and biological to include leaving medications on the medication carts unattended. The Pharmacy consultant will check each medication carts and medication room for impropostorage of medications monthly during scheduled visits. The DON and/or Unimanagers, will monitor each medication cart daily for proper storage of medications and biological to include leaving the medication cart unlocked a unattended during medication pass.	e seen of sime ach e rses cy not a certain con	
	Resident #21 was a 3/12/15 with diagno limited to stroke, high	admitted to the facility on uses that included but were not gh blood pressure,					

PRINTED: 02/09/2016 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPFLIER HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEFICIENCIES 90 S MAIN ST BLACKSTONE, VA 23824	STATEMENT AND PLAN C	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	COMPLETED	
Heritage Hall Blackstone Heritage Heritag			495353	B. WING	-		1	1
F 431 Continued From page 80 hyperlipidemia, atherosclerosis (hardening of the arteries), impaired right renal tubular function and abnormality of gait and mobility. Resident #21's most recent comprehensive MDS (minimum data set) assessment with an ARD (assessment reference date) of 3/12/15. Resident #21 was coded as being moderately impaired in the ability to make daily life decisions scoring 8 out of 15 on the BIMS (Brieff Interview for Mental Status) exam. LPN #7 prepared the following medications for Resident #21: Flonase*** 50 mog (micrograms) 0.005%: 1 spray into both nares daily. Oxybutynin*** 5mg (milligrams): 1 tab (tablet) TID (three times a day); Silicing Scale Novolog (Insulin): 2 units (scheduled) before dinner. At 4:38 p.m. LPN #7 prepared the flonase and oxybutynin tablet. She then took out the glucometer (device used to test blood sugar) and prepared a test strip. She knocked on the Resident's door and explained the procedure. She administered the flonase to Resident #21; one spray into each nares. She then gave him the oxybutynin tablet. After Resident #21; one spray into each nares. She then gave him the oxybutynin tablet and the procedure. She administered the flonase on Resident #21; one spray into each nares. She then gave him the oxybutynin tablet and the procedure. She administered the flonase to Resident #21; one spray into each nares. She then gave him the oxybutynin tablet and the procedure in the lancet, took of the gloves and sanitized her hands. She took out Novolog (insulin) and drew up 2 units per sliding scale. In a separate insulin needle, she drew up 12 units of Novolin N. She then entered the resident's room at 4:47 p.m., while leaving the two bottles of insulin on the medication cart. She shut Resident #21's door while she was in the resident's room. The			NE		9	900 S MAIN ST		
hyperlipidemia, atherosclerosis (hardening of the arteries), impaired right renal tubular function and abnormality of gait and mobility. Resident #21's most recent comprehensive MDS (minimum data set) assessment was an admission assessment with an ARD (assessment reference date) of 3/12/15. Resident #21 was coded as being moderately impaired in the ability to make daily life decisions scoring 8 out of 15 on the BIMS (Brief Interview for Mental Status) exam. LPN #7 prepared the following medications for Resident #21: Flonase*** 50 mog (micrograms) 0.005%: 1 spray into both nares daily, Oxybutynin**** 5mg (milligrams): 1 tab (tablet) TiD (three times a day); Silding Scale Novolog (Insulin): 2 units (scheduled) before dinner. At 4:36 p.m. LPN #7 prepared the flonase and oxybutynin tablet. She then took out the glucometer (device used to test blood sugar) and prepared a test strip. She knocked on the Resident's door and explained the procedure. She administered the flonase to Resident #21; swallowed the tablet she tested his blood sugar. He had a reading of 173. She then disposed of the lancet, took off her gloves and santitized her hands. She took out Novolog (insulin) and drew up 2 units per sliding scale. In a separate insulin needle, she drew up 12 units of Novolin N. She then entered the resident's room at 4:47 p.m., while leaving the brow bottles of insulin on the medication carts to monitor for compliance. The DON of this discrepancies found in these addits with Medication carts to his discrepancies found in these addits with Medication carts unlocked or with Medication carts unlocked or with Medication carts unlocked or with Medication carts with Medication carts unlocked or with Medication carts with medications unsupervised from a licensed unlocked or with execution in these audits with medications unsupervis	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)	BE	
If continuation sheet Page 81 of 99	F 431	hyperlipidemia, ath arteries), impaired abnormality of gait most recent compreset) assessment we with an ARD (asses 3/12/15. Resident moderately impaired life decisions scoria (Brief Interview for LPN #7 prepared the Resident #21: Flonase*** 50 mcg into both nares dai (milligrams): 1 tab day); Sliding Scale blood sugar level of 12 units (scheduler At 4:36 p.m. LPN #0 oxybutynin tablet. glucometer (device prepared a test str. Resident's door and She administered one spray into each the oxybutynin tablet was administered for each one spray into each the lancet, took off hands. She took of the lancet, took off hands. She took of the leaving the the medication cart. Si while she was in the second street was in the second second sup 2 units per sliding the leaving the the medication cart. Si while she was in the second se	erosclerosis (hardening of the right renal tubular function and and mobility. Resident #21's ehensive MDS (minimum data as an admission assessment ssment reference date) of #21 was coded as being ed in the ability to make dailying 8 out of 15 on the BIMS Mental Status) exam. The following medications for (micrograms) 0.005%: 1 spray ly; Oxybutynin**** 5mg (tablet) TID (three times a Novolog (Insulin): 2 units for a of 173; and Novolin N (Insulin): d) before dinner. The prepared the flonase and She then took out the e used to test blood sugar) and ip. She knocked on the ed explained the procedure. The flonase to Resident #21; the nares. She then gave him let. After Resident #21 et she tested his blood sugar. Of 173. She then disposed of the gloves and sanitized her out Novolog (insulin) and drewing scale. In a separate insulinup 12 units of Novolin N. She esident's room at 4:47 p.m., wo bottles of insulin on the he shut Resident #21's door ne resident's room. The		431	The DON is responsible for maintainic compliance. The DON or Unit Manag will perform 2 random weekly audits the medication carts to monitor for compliance. All discrepancies found these audits with Medication carts unlocked or with medications unsupervised from a licensed nurse who corrected at the time of discovery appropriate disciplinary action taken warranted. Results of these audits will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3-14-160	er of ill and as I be	

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Event ID: K8DD11

Facility ID: VA0108



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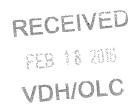
CENTE	49 LOV MEDICAVE	T T T T T T T T T T T T T T T T T T T	13.005 5.21 **	-	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		PLETED
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		495353	B. WING	27,22		01/2	29/2016
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UEDITA	SE HALL BLACKSTO	NF			00 S MAIN ST		
nerma				E	BLACKSTONE, VA 23824	u .	(Ve)
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F 431	back at the medicat this observation, R wheelchair right be Resident #18 was #7 left the medicat Resident #18 was 4/17/15 with diagnorm imited to schizoph depressive disorder pressure, chronic lobstructive pulmor (difficulty swallowing as being severely cability to make dail out of 15 on the Bl status) Exam on a	tion cart at 4:50 p.m. During esident #18 was sitting in a thind the medication cart. sitting near the cart when LPN		431			
	conducted with LP medications were unattended she sta allowed to be left of away. When asked left unattended on stated, "Because a around and take the conduction of the information was prosurvey.	is p.m., administration was above findings. No further rovided during the time of the storage of Medications.					
	documents in part Compartments (in	, the following: "7. cluding, but not limited to rooms. refrigerators, carts and					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495353	B. WING		01/29/2016	
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETIC	NC
F 431 F 441 SS=D	locked when not in transport such item if open or otherwise others. *Novolog-fast actin blood sugar in patie mellitus. This inform Davis's Drug Guide 670. **Novolin N-interme manage high blood or Type 2 diabetes obtained from Davie edition, p. 673. ***Flonase-corticos symptoms of allerg information was ob Guide for Nurses 1 ****Oxybutynin-incr Delays desire to vo obtained from Davie edition, p.924. 483.65 INFECTION SPREAD, LINENS The facility must es Infection Control Presafe, sanitary and of the prevent the of disease and infection Control The facility must es Program under white the program under white the program under white the program of the program of the program under white the program of the program of the program under white program of the program under white program of the prog	drugs and biologicals shall be use, and trays or carts used to use, and trays or carts used to is shall not be left unattended a potentially available to go insulin used to manage high ents with Type 1 or 2 diabetes mation was obtained from a for Nurses 11th edition, p. ediate acting insulin used to I sugar in patients with Type 1 mellitus. This information was s's Drug Guide for Nurses 11th eteroid that decreases the ic or nonallergic rhinits. This tained from Davis's Drug 1th edition, p.347. eases bladder capacity. id. This information was s's Drug Guide for Nurses 11th N CONTROL, PREVENT etablish and maintain an rogram designed to provide a comfortable environment and development and transmission ction.	F4		eident	

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Event ID: K8DD11

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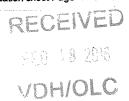
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		PLETED
		495353	B. WING			01/2	; 29/2016
	PROVIDER OR SUPPLIER	NE		S'	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST BLACKSTONE, VA 23824 PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	COMPLÉTION DATE
F 441	(2) Decides what p should be applied to (3) Maintains a recactions related to in (b) Preventing Spre (1) When the Infect determines that a r prevent the spread isolate the resident (2) The facility must communicable dise from direct contact will to (3) The facility must hands after each do hand washing is in professional practic (c) Linens Personnel must hat transport linens so infection. This REQUIREMED by: Based on observation document review a was determined the implement infection 26 residents in the The facility staff fafall mat free from a was unable to be served.	rocedures, such as isolation, to an individual resident; and ord of incidents and corrective infections. Read of Infection tion Control Program resident needs isolation to of infection, the facility must be the prohibit employees with a rease or infected skin lesions with residents or their food, if the ransmit the disease. The require staff to wash their irect resident contact for which dicated by accepted one. Indie, store, process and as to prevent the spread of the record review, it at the facility staff failed to a control practices for one of survey sample, Resident #11. Iteld to maintain Resident #11's a torn area, exposing foam that sanitized.	F	141	Identification of Deficient Practice(and Corrective Action(s): All other resident's utilizing fall mats while bed may have potentially been affected. A complete documented environmental walkthrough of the fact will be conducted by the administrate maintenance director, and environme services director to identify residents risk. All resident fall mats identified are torn will be removed from service replaced immediately at the time of discovery. Systemic Change(s): The facility Infection Control policy cleaning and storing resident equipm has been reviewed and no changes as warranted at this time. The nursing and environmental staff will be inserby the DON and/or ADON on the facility's infection control policy and procedure. To include the protocol to used for cleaning, storing and inspectall mats for cracks, tears or being unserviceable.	cility or, ontal at that e and for ent re staff viced	
	The findings include	16:			If continu	ation chee	Page 84 of 9

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Facility ID: VA0108

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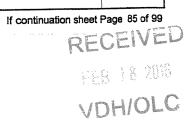
PRINTED: 02/09/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMP	PLETED
		495353	B. WING			01/2	9/2016
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F 441	Resident #11 was a 6/15/15 with diagnor limited to: muscle v (a problem with the heartbeat) and low #11's most recent of quarterly assessment reference date) of cognitive skills for eseverely impaired, being totally dependence on the comproblem onset date mat at bedside, chewhen resident in being totally dependence on 1/27/16 at 2:40 Resident #11 was of the dining room. Or room revealed the and sitting on the firesident's bed. At a inches long by one on the edge of the sticking out of the problem on the firesident's fall mats without torn areas, torn we put in a woor go to the supervision." When aske areas on Resident	admitted to the facility on oses that included but were not weakness, *cardiac arrhythmia rate or rhythm of your blood pressure. Resident MDS (minimum data set), a ent with an ARD (assessment 12/24/15, coded the resident's daily decision making as being Resident #11 was coded as dent of one staff with unit. In prehensive care plan with a e of 6/18/15 documented, "Fall eck placement q (every) shift ed" p.m. and 1/28/16 at 8:00 a.m., observed in a wheel chair in observation of Resident #11's resident's fall mat was folded oor against the foot of the orn area approximately four half inch wide was observed mat. Foam was exposed	F		Monitoring: The DON and Environmental Director responsible for maintaining compliar The DON or Environmental Director and/or designee will complete daily environmental rounds to monitor fall for compliance. The Environmental will also monitor for proper storage during daily room cleaning. Any neg findings will be corrected at time of discover and reported to the DON and Environmental Director. Aggregate findings of the audits will be submitted the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. Compliance Date: 3-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1	mats Staff gative	

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

Event ID: K8DD11

Facility ID: VA0108



PRINTED: 02/09/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL [*] A. BUILDI	TIPLE CONSTRUCTION NG	CON	COMPLETED		
		495353	B. WING		1	/29/2016	
	PROVIDER OR SUPPLIER BE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP 900 S MAIN ST BLACKSTONE, VA 23824	CODE		
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F 441	resident's fall mat a When asked if Residuring the day shift only naps during the time, CNA #1 was and shown the fall report the torn fall report seen anyone keep a torn fall mat CNA #2 stated, "I da new one." On 1/28/16 at 5:52 staff member) #1 (the director of nursabove findings. The facility policy ti Disinfection of Res Equipment, includir medical equipment disinfected according Disease Control) redisinfection and the and Health Adminis Pathogens Standar specifically documents.	and it was utilized by night shift. ident #11 ever took naps, CNA #1 stated the resident e day once in a while. At this taken to Resident #11's room mat. CNA #1 stated she would mat and removed the mat from p.m., an interview was A #2. CNA #2 was asked who rensuring fall mats were kept in torn areas. CNA #2 stated rone did that and she had do that. When asked how to t clean and free of bacteria, on't think you can. I would get p.m., ASM (administrative the administrator) and ASM #2 sing) were made aware of the		41			

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
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		495353	B. WING			1 017.	29/2010
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F 441	*This information w https://www.nlm.nll tml	vas obtained from the website: n.gov/medlineplus/arrhythmia.h	- Additional of the second of	141	F502		
F 502 SS=D	The facility must preservices to meet the	NISTRATION rovide or obtain laboratory ne needs of its residents. The sile for the quality and timeliness	F:	502	Corrective Action(s): Resident #3's attending physician been notified that the facility failed obtain a HgbA1c and an Lipid Pan ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs.	i to el y	
	by: Based on staff into and facility docume that the facility staff	NT is not met as evidenced erview, clinical record review, ent review, it was determined failed to obtain physician tests 1 of 26 residents in the sident #3			Identification of Deficient Practi & Corrective Action(s): All other residents who had physic ordered lab tests may have potenti been affected. A 100% audit of al resident's lab orders will be compli- identify residents at risk. All nega- findings will be corrected at the ti	cian ally ll leted to ative	
	physician ordered HgbA1c, or Hemoretests for January 2	at measures the amount of			discovery. The attending physicia be notified of the missing labs, lal obtained timely and labs obtained without a physician order. A facil Incident & Accident Form will be completed.	ns will bs not ity	
	glycated hemoglob measure your bloc months. It can giv you have manage or 3 months. Web	oin in your blood. It is used to od sugar control over several e a good estimate of how well d your diabetes over the last 2			Systemic Changes: The facility policy and procedure been reviewed and no changes ar warranted at this time. The laboratracking system has been reviewed implemented to track and validat required lab work has been compared.	e atory ed and e that oleted	
	ordered together the heart disease. The shown to be good	group of tests that are often of determine risk of coronary ey are tests that have been indicators of whether someone heart attack or stroke caused			per physician order and policy are procedure. The DON and/or Rep Nurse Consultant will inservice a licensed staff on physician order laboratory-testing, protocols, & system used.	gionai all ed	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353	B. WING	garjama ninajadom		1	29/2016
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HEDITAG	SE HALL BLACKSTO	NF			00 S MAIN ST		
HERITAG	SE MALE BLACKS TO			В	LACKSTONE, VA 23824		
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F 502	by blockage of blocarteries (atheroscle http://labtestsonline pid/tab/glance The findings include Resident #3 was ac 4/22/09 with the dia Alzheimer's demen Hepatitis C, high blocontractures, aphast The most recent MI an annual assessm Reference Date) of coded as severely of make daily life decitotal care for all are Living) and was incompleted to the contractures of the clinical recently signed POS for November 2015 on 11/14/15. This F8/22/13 for "HGBA1 of this lab (laboratorevealed the test was and 10/23/15, indicated was January 20 on 1/28/16, the test when other January (on 1/21/16.) In addition, the POS 8/22/13 for "Lipid events lab located in the contraction of the clinical contraction	od vessels or hardening of the prosis). Website accessed along/understanding/analytes/li	F	502	Monitoring: The DON is responsible for maintain compliance. The DON and/or designed will complete the Facility Lab audit to weekly to monitor for compliance. At negative findings will be reported to attending physician and disciplinary action will be taken as warranted. The results of these audits will be reported the Quality Assurance Committee for review, analysis, & recommendation change in facility policy, procedure, and/or practice. Completion Date: 3-14-16	ee ool ny the e d to	

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		LETED
		495353	B. WING			01/2	9/2016
	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 S MAIN ST BLACKSTONE, VA 23824	<u> </u>	
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F 502	it was due was Jan review on 1/28/16, performed when ot completed (on 1/21). On 1/28/16 at 3:00 conducted with RN was the nurse that She provided her "which she tracked month. The "Routi included Resident: the HgA1C test wa along with other or provided the lab sli completed which is labs needed to be marked "TSH (thyrinstead of "Hemog was a mistake and the HgA1c test insit the Lipid, her "Routindicated the lab wishe had not intende 2016. When asked labs with her lab so had been at the fact and in that time had to the monthly POS checked new phonoduring the month. ***According to Moedition, 2002. St. I 1712, TSH (Thyroida blood test used to the month of the st.)	uary 2016. As of survey this the test had not been her January 2016 labs were	F	502			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		PLE CONSTRUCTION		E SURVEY IPLETED
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		495353	B. WING	Newman		01/	29/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	SE HALL BLACKSTO	NE			900 S MAIN ST BLACKSTONE, VA 23824		
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F 502	A review of the facil Test Results" docur identify and order do based on diagnostic The staff will process arrange for tests. 3 radiology provider, or report test results to A review of the care reveal any intervent obtaining and monit On 1/28/16 at the erapproximately 5:30 #1(Administrative/C Administrator), ASM RN #1 (Registered of Nursing), and AS consultant) were ma further information visurvey. According to Funda Edition, Lippincott V Page 165, Laborato in relation to the clie problems and treatmesults can also ider problemsSometim	ity policy, "Lab and Diagnostic mented: 1. The physician will iagnostic and lab testing and monitoring needs. 2. It is test requisitions and it. The laboratory, diagnostic or other testing source will be the facility" It plan for Resident #3 failed to it is plan for Resident #3 failed to it is specifically identifying the toring of labs as ordered. Ind of day meeting at p.m., the ASM orporate Staff, the M #2 (the Director of Nursing), Nurse, the Assistant Director M #3 (the regional nurse ade aware of the findings. No was provided by the end of the mentals of Nursing, 5th Villiams & Wilkins, 2007. The tests are always interpreted ent's underlying healthment modalities. These intify actual or potential healthmes, laboratory tests and	F5	502			
F 504	effectiveness of nur- treatment." And on of continuous client document, the client	t record should contain all nts, planning, interventions, that client."	F 5	04			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353	B. WING			1	C /29/2016
	PROVIDER OR SUPPLIER	and the second s		S7 90	REET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST LACKSTONE, VA 23824		
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F 504 SS=D	ORDERED BY PH' The facility must pr services only when physician. This REQUIREMED by:	YSICIAN ovide or obtain laboratory ordered by the attending NT is not met as evidenced	F 5	504	F504 Corrective Action(s): Resident #3's attending physician h been notified that the facility obtain TSH lab tests without a physician o A facility Incident & Accident form been completed for laboratory test. Identification of Deficient Practic & Corrective Action(s): All other residents may have potent	ed a rder. has e(s)	
	and facility docume that the facility staff without a physician the survey sample; The facility staff perstimulating hormon Resident #3 without	erview, clinical record review, ent review, it was determined by performed a laboratory test is order for 1 of 26 residents in Resident #3. If ormed a TSH (thyroid e)* laboratory (lab) test for ta physician's order. By's Medical Dictionary, sixth			been affected. A 100% audit of resclinical records will be completed tidentify residents who may have halaboratory tests completed without physician order. All negative findin will be corrected at the time of discand the attending physician will be notified. A Facility Incident & Acc form will be completed for each incident.	o d a gs overy	
	edition, 2002. St. L 1712, TSH (Thyroid a blood test used to helping to differenti hypothyroidism.	ouis, MO: Mosby, Inc. Page is stimulating hormone test) is measure TSH concentration, ate primary from secondary			Systemic Changes: The facility policy and procedure here been reviewed and no changes are warranted at this time. Licensed stawill be inserviced on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to	uff i	
	A/22/09 with the dia Alzheimer's demen Hepatitis C, high bl contractures, apharman annual assessman Reference Date) of	dmitted to the facility on agnoses of but not limited to tia, schizophrenia, anxiety, cod pressure, emphysema, sia, and depression. DS (Minimum Data Set) was ment with an ARD (Assessment 11/13/15. The resident was cognitively impaired in ability to			obtaining the lab test.		

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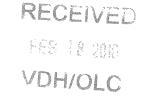
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		E SURVEY PLETED
		495353	B. WING			\$	C 29/2016
		433333	3: 11.10		STREET ADDRESS, CITY, STATE, ZIP CODE	01/	29/2010
NAME OF	PROVIDER OR SUPPLIER						
HERITAG	SE HALL BLACKSTON	VE			000 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 504	make daily life decisitotal care for all arealizing) and was incompleted. A review of the clinic dated 1/21/16 for a order could be located. On 1/28/16 at 3:00 periodicted with RN was the nurse that the She provided her "Found which she tracked lamonth. The "Routing included Resident # an HgA1C** test was 2016 along with other provided the lab slip 1/21/16, that was conthered the lab staff which late this slip she had man "Hemoglobin A1c." mistake and that she HgA1c test instead of the she was a test that glycated hemoglobin measure your blood months. It can give you have managed or 3 months. Websithtp://www.nlm.nih.go.3640.htm A review of the facility and order dispased on diagnostic	sions. The resident required as of ADL's (Activities of Daily ontinent of bowel and bladder. Cal record revealed lab results TSH level. No physician's red for this lab. D.m., an interview was the (Registered Nurse) who racked and ordered labs. Routine Lab Schedule" sheet labs to be performed for the ne Lab Schedule" provided 3's name and had identified as to be drawn in January ler ordered labs. RN #4 then of for Resident #3 dated ampleted which identified to labs needed to be drawn. On rked "TSH" instead of She stated that it was a le should have marked the lof the TSH. Set measures the amount of an in your blood. It is used to sugar control over several a good estimate of how well your diabetes over the last 2	F	504	Monitoring: The DON is responsible for maintain compliance. The DON, and/or design will review all lab tests obtained week to ensure that all resident lab tests obtained had the appropriate physicia order for the lab tests prior to obtain. Any negative findings will be reported the attending physician and the appropriate disciplinary action taken staff involved. The results of these awill be reported to the Quality Assura Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: 3-14-160	nee kly un ng. ed to for adits ance	

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Control of the Contro	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	CONSTRUCTION	(X3) DATE	
STATEMENT AND PLAN OF	OF DEFICIENCIES F CORRECTION	IDENTIFICATION NUMBER:					LETED
						C	
		495353	B. WING			01/2	9/2016
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
НЕВІТАС	E HALL BLACKSTO	NE			S MAIN ST ACKSTONE, VA 23824		
1111111111				- DL	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETION DATE
F 504	radiology provider, report test results to A review of the car reveal any intervent obtaining and month of the capproximately 5:30 #1(Administrative/OAdministrator), ASRN #1 (Registered of Nursing), and Ast consultant) were infurther information	3. The laboratory, diagnostic or other testing source will o the facility" e plan for Resident #3 falled to the specifically identifying the itoring of labs as ordered. end of day meeting at 0 p.m., the ASM		504			
F 514 SS=D	Edition, Lippincott Page 165, Laborat in relation to the claresults can also id problemsSome diagnostic procedureffectiveness of nutreatment." And o of continuous clier document, the clie pertinent assessmand evaluations for 483.75(i)(1) RES RECORDS-COMFLE	amentals of Nursing, 5th Williams & Wilkins, 2007. Fory tests are always interpreted ient's underlying health trent modalities. These entify actual or potential health times, laboratory tests and ures are used to judge the ursing interventions or medical in page 236, "As an instrument of care and as a legal entrecord should contain all ents, planning, interventions, or that client." PLETE/ACCURATE/ACCESSIB maintain clinical records on each ance with accepted professional	F	514	F514 Corrective Action(s): Resident #7's attending physician had been notified that the facility staff fatto discontinue a dressing change after pressure ulcer had healed and also documented that the treatment was a	er a	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	1	MPLETED C	
		495353	B. WING			Į.	29/2016	
, 2	PROVIDER OR SUPPLIER SE HALL BLACKSTO	NE		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST SLACKSTONE, VA 23824			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 514	standards and prac	tices that are complete; nted; readily accessible; and	F 5	514	on the January treatment administration record in error. A facility incident and accident form has been completed for incident.			
	information to ident resident's assessm services provided;	ening conducted by the State;			Identification of Deficient Practices Corrective Action(s): All other residents may have potentia been affected. A 100% audit of resid medical records for the last 30 days w be conducted by the DON, ADON, U Manager, and or designee to identify	lly ent's vill		
	by: Based on staff inte review and clinical i determined that fac complete and accur	rview, facility documentation record review it was ility staff failed to maintain a rate clinical record for one of survey sample; Resident #7.			residents at risk for inaccurate documentation. To include all MAR's TAR's for inaccurate documentation. negative findings will be clarified and correct as applicable at time of discovand the attending physician notified. facility Incident & Accident form will completed for each negative finding.	All I/or ery A		
	an order for a dress ulcer was healed ar				Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include	:		
	and readmitted on a included but not lim type two diabetes, s swallowing), severe and muscle weakner recent MDS (minim change assessment The resident was conterns and never be	Imitted to the facility on 8/4/15 12/11/15 with diagnoses that ited to high blood pressure, stroke, dysphagia (difficulty peripheral vascular disease ess. Resident #7's most um data set) was a significant at with an ARD of 12/18/15. Ended as never understanding eing understood by others for esident #7 was coded as being			standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information the medical record, the Physician Or the MAR's and the TAR's according the acceptable professional standards practices.	n in ders,		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495353	B. WING			1	29/2016
	PROVIDER OR SUPPLIER SE HALL BLACKSTO	NE		90	TREET ADDRESS, CITY, STATE, ZIP CODE DO S MAIN ST LACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 514	severely impaired in decisions. The restotally dependent of eating, personal hy Review of Resident wound care special dated 9/18/15 that in "Stage 3 pressure in (Resolved on 9/18/discovered on 8/28 into place. Further review of the September 2015 To Record) that docum sacrum with DWC, apply 4X4 allevyn** was initiated on 9/19/18/15 (the resolved went to the hospital Resident #7 arrived 12/11/15. Review of the phys 1/15/16 revealed an following: "Cleanse (dermal wound clean periwound, apply second following: This country of the December 1/28/16, the day of Review of the December 1/28/16, the day of Review of the December 1/28/16, the day of the Resident #7 has the sident #7 has the side	in the ability to make daily ident was coded as being in staff with transfers, dressing, giene and bathing. It #7's clinical record revealed a list evaluation assessment documented the following: wound of the sacrum 15)." This wound was /15 and treatments were put in a clinical record revealed the AR (Treatment Administration mented the following: "Cleanse apply Santyl* ointment and red (every day)." This order 0/15 and discontinued on a date of the wound). It is all record revealed that she is on 12/6/15 for pneumonia. It back to the facility on ician order sheet dated in order that documented the sacral area with DWC anser*), apply skin prepantyl, and allevyn QD order was discontinued on survey. It is all record of the wound on survey. It is all record of the wound on survey. It is all record of the wound on survey. It is all record of the wound on survey. It is all record of the wound on survey.		514	Monitoring: The DON is responsible for maintaini compliance. The DON, and/or design will audit medical records, MAR's & TAR's weekly coinciding with the car plan calendar to monitor for complian Any/all negative findings will be clar and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will provided to the Quality Assurance Committee for analysis and recommendations for change in facili policy, procedure, and/or practice. Completion Date: 3 - 14 - 16	re re ice. ified d	

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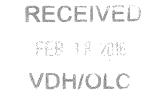
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	, COM	E SURVEY MPLETED	
		495353	B. WING		01/	/29/2016	
	PROVIDER OR SUPPLIER GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP C 900 S MAIN ST BLACKSTONE, VA 23824	CODE		
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F 514	Continued From pa	age 95	F 5	14			
	was conducted. R	p.m., wound care observation esident #7's skin on her No wound or breakdown was					
	was conducted with nurse) #6, one of the the January 2016 The When asked if she on the TAR she state have never seen of "You mean when w	oximately 4 p.m., an interview in LPN (licensed practical ne nurses who signed off on TAR for the sacral dressing. knew what check marks mean ited, "What do you mean? I neck marks." She then stated, we give medications? It turns is screen that we did the					
	treatment." When shift the majority of Resident #7 she st Resident #7's wour the arterial wounds When asked if Resulcer she stated, "N	asked if she had worked 3-11 the month of January with ated, "Yes." When asked about hids, LPN #6 only mentioned on Resident #7's left foot. ident #7 had a sacral pressure to. She used to have an area When asked if she					
	administered the S "Well I was actually because she had n order." I was puttin weeks ago when the we were supposed	antyl order LPN #6 stated, wondering what was going on o area but there was still an g the dressing on until a few he day shift nurse told me that to discontinue the order					
	because the wound she could remembe this information she a few weeks ago." that her signature we of the month of Jar treatment, she stat treatments because	I had healed." When asked if er the date that she found out e stated, "No, I just know it was When LPN #6 was informed was documented the majority nuary as applying the ed, "Sometimes I just check off e she has a ton of wounds. I					
	that. I have to be m	der was still there. I tend to do ore careful. I should have just					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COM	(X3) DATE SURVEY COMPLETED C	
495353		495353	B. WING			01/29/2016	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	Y (FACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 514	discontinued the tre nurse did it." Wher discontinue the ord wound was healed other nurse was go On 1/28/15 at 4:19 conducted with LPN When asked what to December 2015 an stated, "The checks given." When asked a treatment was given." When asked a treatment was given." On 1/28/15 at 4:21 conducted with RN unit manager. Whe wound order she st somehow written we back from the facilit who is responsible discharge orders sh so me." When asked hospital discharge order just came ove When asked the pr she stated that she on the discharge lis ensure medications who is responsible orders on weekend "Our admissions or week when the sup asked if Resident # 9/18/15 (date of resident #	eatment. I thought the other nasked why LPN #6 did not er when she first noticed the she stated, "I thought the	F5	514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495353		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			C 01/29/2016	
		B. WING					
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE				90	REET ADDRESS, CITY, STATE, ZIP CODE DIS MAIN ST LACKSTONE, VA 23824		
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	(X5) COMPLETION DATE	
F 514	January 2016 TARS the medication or to When asked if this provided if the wou "No." When asked discontinued the or resident's sacral we "Yes, I definitely ne things." When ask that this treatment not given she state check off a medical was not." On 1/28/15 at 4:30 made aware of the information was pre survey. Facility policy titled documents in part incidents, accidents condition must be in The following quota Perry's Fundament (2005, p. 477): "De written or printed th proof for authorized within a client med nursing practice. In accurate, compreh retrieve critical data track client outcom standards of nursin client record provice	S she stated, "Checks mean reatment had been given." treatment should have been nd was healed, she stated, if nursing should have der when they realized the bund was healed she stated, ed other eyes to check these ed if it was ok to document was given when it was in fact d, "No, nursing should never tion or treatment was given if it p.m., administration was above concerns. No further esented during the time of , Charting and Documentation, the following: "3. All s, or changes in the resident's	F	514			

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NAME OF PROVIDER OR SUPPLIER CALL DESCRIPTION STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE SUMMARY STATEMENT OF DEFICIENCES 100 S MAIN ST BLACKSTONE, VA 23824 (EACH DEFICIENCY MUST BE PROCEDED BY PILL REGULATORY OR USE DEMINIFINE OF DEFICIENCES (EACH DOPE CITY OR USE DEMINIFINE OR DEFICIENCY)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	COMPLETED	
HERITAGE HALL BLACKSTONE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 98 *Santyl ointment is an ointment that is applied directly to the wound and digests collagen in necrotic (dead) tissue. Use of Santyl should be terminated when debridement of necrotic tissue is complete and granulation is well established. This information was obtained from http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm ?setid=a7bf0341-49ff-4338-a339-679a3f3953d. *** Allevyn- waterproof dressing that requires no additional tape or bandage. Suitable for exuding wounds (wounds with drainage). This information was obtained from was obtained from additional tape or bandage. Suitable for exuding wounds (wounds with drainage). This information was obtained from	495353			B. WING			1 " 1	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 514 Continued From page 98 *Santyl ointment is an ointment that is applied directly to the wound and digests collagen in necrotic (dead) tissue. Use of Santyl should be terminated when debridement of necrotic tissue is complete and granulation is well established. This information was obtained from http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d. ** Allevyn- waterproof dressing that requires no additional tape or bandage. Suitable for exuding wounds (wounds with drainage). This information was obtained from was obtained from	NAME OF PROVIDER OR SUPPLIER				900	S MAIN ST ACKSTONE, VA 23824		
*Santyl ointment is an ointment that is applied directly to the wound and digests collagen in necrotic (dead) tissue. Use of Santyl should be terminated when debridement of necrotic tissue is complete and granulation is well established. This information was obtained from http://dailymed.nlm.nih.gov/dailymed/druglnfo.cfm?setid=a7bf0341-49ff-4338-a339-679a3f3f953d. *** Allevyn- waterproof dressing that requires no additional tape or bandage. Suitable for exuding wounds (wounds with drainage). This information was obtained from	PRÉFIX	(FACH DEFICIENCY MUST BE PRECEDED BY FULL				(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	(X5) COMPLETION DATE
	F 514	*Santyl ointment is directly to the wour necrotic (dead) tiss terminated when do complete and gran This information was http://dailymed.nlm ?setid=a7bf0341-4 ** Allevyn- waterpra additional tape or be wounds (wounds was obtained from	an ointment that is applied and and digests collagen in sue. Use of Santyl should be ebridement of necrotic tissue is nulation is well established. as obtained from inh.gov/dailymed/druglnfo.cfm 9ff-4338-a339-679a3f3f953d. oof dressing that requires no pandage. Suitable for exuding with drainage). This information	F	514			

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