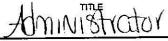
PRINTED: 05/04/2018 FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _ B. WING VA0118 04/12/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD **HERITAGE HALL VIRGINIA BEACH** VIRGINIA BEACH, VA 23462 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) 1D (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 000 F 000 Initial Comments RECEIVED An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection MAY 1 1 2018 was conducted 04/09/18 through 04/12/18. Three complaints were investigated during the survey. Corrections are required for compliance VDH/OLC with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 86 at the time of the survey. The survey sample consisted of 22 current Resident reviews and 3 closed record reviews. F 001 F 001 Non Compliance POLICIES AND PROCEDURES 12 VAC 5-371-140 (A) The facility was out of compliance with the Cross Reference to F tag 607 following state licensure requirements: Cross Reference POC for F 607 This RULE: is not met as evidenced by: The facility was not in compliance with the RESIDENT ASSESSMENT AND CARE following Virginia Rules and Regulations for the PLANNING Licensure of Nursing Facilities. 12 VAC 5-371-250 (A) Cross Reference to F tag 641 **POLICIES AND PROCEDURES** Cross Reference POC for F 641 12 VAC 5-371-140 (A) Cross reference to F tag 607 12 VAC 5-371-250 (C, F, I) Cross Reference to F tag 657 RESIDENT ASSESSMENT AND CARE Cross Reference POC for F 657 PLANNING 12 VAC 5-371-250 (A) Cross reference to F tag DIRECTOR OF NURSING 641 12 VAC 5-371-200 (B.1.ii) Cross Reference to F tag 658 12 VAC 5-371-250 (C, F, I) Cross reference to F tag 657

LABORATORY DIRECTOR'S OR PROVIDERSUPPLIER REPRESENTATIVES SIGNATURE SUPPLIER REPRESENTATIVES SIGNATURE OF THE SUPPLIER SIGNATURE SIGNATURE OF THE SUPPLIER SIGNATURE SIGNA

12 VAC 5-371-200 (B.1.ii) Cross reference to F

DIRECTOR OF NURSING



Cross Reference POC for F 658



State of Virginia

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:) DATE SURVEY COMPLETED
	8	VA0118	B. WING		04/12/2018
NAME OF PE	ROVIDER OR SUPPLIER	p+9700470300700703000	DDRESS, CITY, STAT	NOVIDE	
HERITAGE	HALL VIRGINIA BEAC	M000000 - 100000000	NIEL SMITH ROA A BEACH, VA 234		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 001	tag 658 NURSING SERVICE 12 VAC 5-371-220 (at tag 684) 12 VAC 5-371-220 (at tag 685) 12 VAC 5-371-220 (at tag 685) 12 VAC 5-371-220 (at tag 685) PHARMACEUTICAL 12 VAC 5-371-300 (at tag 685) 12 VAC 5-371-300 (at tag 685) CLINICAL RECORD 12 VAC 5-371-360 (at tag 685) INFECTION CONTINUES	A, B) Cross reference to F C) Cross reference to F tag A) Cross reference to F tag L SERVICES A) Cross reference to F tag H) Cross reference to F tag C) C) C) C) C) C) C) C) C) C	F 001	NURSING SERVICES 12 VAC 5-371-220 (A, B) Cross Reference to F tag 684 Cross Reference POC for F 684 12 VAC 371-220 (D) Cross Reference to F tag 695 Cross Reference POC for F695 12 VAC 5-371-220 (A) Cross Reference to F tag 757 and 758 Cross Reference POC for F 757 and F 7. PHARMACEUTICAL SERVICES 12 VAC 5-371-300 (A) Cross Reference to F tag 755 Cross Reference POC for F 755 12 VAC 5-371-300 (H) Cross Reference to F tag 756 CLINICAL RECORDS 12 VAC 5-371-360 (A) Cross Reference to F tag 842 Cross Reference to POC for F 756 INFECTION CONTROL 12 VAC 5-371-180 (A) Cross Reference to F tag 880 Cross Reference POC for F 880	58
				Completion Date: May 25, 2018	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 05/04/2018 FORM APPROVED OMB NO. 0938-0391

NTERS F	OR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-039
MENT OF E	DEFICIENCIES PRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		495234	B. WING		04/12/2018
ME OF PROV	JIDER OR SUPPLIER	de Caracter de Car	1	STREET ADDRESS, CITY, STATE, ZIP CODE	
DITAGE H	IALL VIRGINIA BEAC	н		5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	
	0.00			PROVIDER'S PLAN OF COR	RECTION (%5)
X4) ID REFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETIC
E 000 1	nitial Comments		E 00	o	
	survey was conduct 04/12/18. The facili compliance with 42 Requirement for Lor Three complaint(s) survey.	ng-Term Care Facilities. were investigated during the 90 certified bed facility was 86			
at	at the time of the su	urvey. The final survey sample rent Resident reviews and 3			
	closed record revie				
- 10	INITIAL COMMEN		F0	00	
	survey was conduct 04/12/18. Three of during the survey. compliance with 42	Medicare/Medicaid standard cted 04/09/18 through omplaints were investigated Corrections are required for 2 CFR Part 483 Federal Long ments. The Life Safety Code follow.			
	at the time of the s consisted of 22 cu closed record revi				
F 607 SS=D	ATT 1 400 40/L	nt Abuse/Neglect Policies)(1)-(3)	F	607 F607 Corrective Action(s): Employee #25 a contract p	physical
	§483.12(b) The fa implement written	acility must develop and policies and procedures that:		therapist has had a backgro completed by the appropri agency. A facility Incident form has been completed	ate state t & Accident
	neglect, and expl	phibit and prevent abuse, oitation of residents and of resident property,		Torin has been completed	
	§483.12(b)(2) Es	tablish policies and procedures	8		(X5) DAI

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.

Fecility ID: VA0118

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	04/	12/2018
HERITAGE HALL VIRGINIA BEACH 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		nove 50
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROMDER'S PLAN OF CORRE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROMDER'S PLAN OF CORRECTIVE ACTION SHOULD PREFIX (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETION DATE
F 607 Continued From page 1 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to obtain a criminal record background check through the Virginia State Police for 1 of 25 employees (employee #25). The findings included: The facility staff failed to obtain a criminal record background check through the Virginia State Police for employee #25-a contracted physical therapist. The surveyor reviewed 25 newly hired employee personnel files on 4/11/18. Employee #25 was hired on 3/10/17 as a physical therapist (PT). Employee #255 personnel file did not contain a criminal record background check. The HR director stated she dicht see one and then stated contracted staff are responsible for completing their records. The surveyor informed the administrator and the administrator and the administrator and the administrator stated the concern would be addressed with the contracted staff. The surveyor requested the facility policy on hiring /screening of new employees on 4/11/18.	ay have Therapy Epartment Intract Intr	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	55 V/W 12	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495234	B. WING	0,,777	C 04/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	1	3000 A600	STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
F 607	"Background Screen 4/12/18. The policy of Personnel/Human Redesignee, will conduct checks, reference checks (including fing required by state law application for emploinvestigation will be it employment or offer. The surveyor informed director of nursing an nurse of the above fing meeting on 4/11/18 and No further information 4/12/18.	ed the facility policy titled ing Investigations" on ead in part "1. The esources Director, or other extremployment background ecks and criminal conviction gerprinting as may be on persons making yment with this facility. Such initiated within two days of of employment." The deterministrator, the matter of the corporate registered and in the end of the day at 5:15 p.m. In was provided prior to exit	F 60		
F 641 SS=E	CFR(s): 483.20(g) §483.20(g) Accuracy The assessment mu- resident's status. This REQUIREMEN by: Based on staff inter review, the facility st MDS assessments f (Residents #8, #26, #48, #50, and #70). The findings include 1. For Resident #8,	of Assessments. st accurately reflect the T is not met as evidenced view and clinical record aff failed to maintain accurate for 11 of 25 Residents #46, #85, #76, #79, #30, #41, d. the facility staff failed to e MDS (minimum data set)	F 64	Corrective Action(s): Resident #8 has had their most r MDS modified to accurately coo P to reflect the use of a Chair an alarm. A facility Incident & Acc form was completed for this inc Resident #26 has had their most MDS modified to accurately coo sections J for falls, section N fo medications in use & section O accurately reflect the Flu Vacci offered in facility. A facility Inc Accident form was completed f incident.	de section d/or Bed sident ident. recent de r current to ne was

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		495234	B. WNG			04/12/2018
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	
	AME OF PROVIDER OR SUPPLIER ERITAGE HALL VIRGINIA BEACH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 3 The record review revealed that Resident #8 had been admitted to the facility 10/02/17. Diagnoses included, but were not limited to, dementia without behavioral disturbances, diabetes, hyperlipidemia, and chronic kidney disease. Section C (cognitive patterns) of the Residents quarterly MDS assessment with an ARD (assessment reference date) of 01/08/18 was coded 1/1/1 to indicate the Resident had problems with long and short term memory and had modified independence in cognitive skills for daily decision making. Section P (restraints) was not coded to indicate the Resident used a chair and/or bed alarm. The most current POS (physician order summary) included an order for bed/chair alarms the date of this order was documented as 10/29/17. The comprehensive care plan included the problem area of falls. Interventions included, but		558	BO DANIEL SMITH ROAD		
HERITAGE	HALL VIKGINIA BEAU	JH .	I	VIE	RGINIA BEACH, VA 23462	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 641	Continued From pag	ge 3	F	641	Resident #46 has had their most recent MDS modified to accurately code section. N- Medications to reflect the correct	on
	The record review re	evealed that Resident #8 had			number of days insulin was administere	va"
	been admitted to the	e facility 10/02/17. Diagnoses		ł	in the last 7 days. A facility Incident &	
	included, but were r	not limited to, dementia			Accident form was completed for this	
	without behavioral d	listurbances, diabetes,			incident.	
	hyperlipidemia, and	chronic kidney disease.				
	(2)				Resident #85 has had their most recent	
					Discharge MDS assessment modified to	
				18	accurately reflect the discharge location	
	(assessment referen	nce date) of 01/08/18 was			of resident #85 to the Hospital at time of discharge. A facility Incident & Accide	
					form was completed for this incident.	AII.
					torm was completed for and metablic	
					Resident #76 has had their most recent	,
				Ĭ	MDS modified to accurately code secti	on
		te the Resident used a chair			O to reflect the use of a Chair and/or B	ed
	and/or bed alarm.		â	ŀ	alarm. A facility Incident & Accident	
					form was completed for this incident.	
	The most current P	OS (physician order		l	B 11 1201 1 111 1	
	summary) included	an order for bed/chair alarms			Resident #79 has had their most recent	
	the date of this orde	er was documented as		1	MDS modified to accurately code secti K to reflect the current weight and sect	
	10/29/17.			ì	P to reflect the use of a Trunk Restrain	
					facility Incident & Accident form was	
					completed for this incident.	
					,	
	were not limited to	Bed/chair alarm as ordered.		8	Resident #30 has had their most recent	
	SECON MARINAGO ANTIGO A PARINCIPA A ANTIGO				MDS modified to accurately code sect	ion
		oximately 3:45 p.m., the	1		I to reflect the accurate diagnosis of	
		ed the MDS coordinator. After		.0	dementia for resident 30. A facility Incident & Accident form was comple	ted
iš	reviewing the MDS, the coordinator verbalized to the surveyor that the MDS had been inaccurately				for this incident.	
					TOT THE STREET	
	coded in regards a	larms.			Resident #41 has had their most recent	t.
					MDS modified to accurately code sect	ion
	1	proximately 4:00 p.m., the			I to reflect the accurate diagnosis of C	HF
		mployee from the activity			and Hypertension. A facility Incident	&
	department checke	ed the Residents chair alarm.			Accident form was completed for this	
	The chair alarm was order.	as observed to be in working	i i		incident.	
	The administrative	staff were notified of the issue				ľ

FORM ADDROVED

		D HUMAN SERVICES				0. 0938-0391
CENTERS	FOR MEDICARE &	MEDICAID SERVICES				SURVEY
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 12 20 20 20 0 10 0 10 0 10 10 10 10 10 10 10 10 10	PLE CONSTRUCTION	COME	PLETED
		495234	B. WING_		1	/12/2018
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			ŀ	5580 DANIEL SMITH ROAD		
HERITAGE	HALL VIRGINIA BEAC	Н		VIRGINIA BEACH, VA 23462		,
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	regarding the MDS a with the survey team No further information provided to the survey dead to the assessment in regard plavix, falls, and flu vaccine. The record review had been admitted Diagnoses include cerebral infarction hypertension, contaphasia. Section C (cognitic quarterly MDS as (assessment referred a BIMS (brief intersummary score of conditions) had been coded receiving anticoal (special treatment had been coded offered a flu vaccine orders revealed dead to the survey dead of the forders revealed dead to the survey dead to th	assessment during a meeting on 04/12/18 at 3:12 p.m. on regarding this issue was vey team prior to the exit 6, the facility staff failed to express to the medications aspiring and in regards to the Residents revealed that Resident #26 It to the facility 02/01/17. In do but were not limited to, adult failure to thrive, essential stipation, chronic rhinitis, and expressed that Residents revealed that Resident #26 It to the facility 02/01/17. In do but were not limited to, adult failure to thrive, essential stipation, chronic rhinitis, and expressed that Residents research with an ARD rence date) of 02/02/18 included expressed for mental status) for 15. Section J (health resident was received to indicate the resident was regulant medications. Section O ents, procedures, and programs) to indicate the Resident was not cine at the facility. Residents current physician that the Resident was receiving aspirin and plavix. Per the RAI	F6	Resident #48 has had their me MDS modified to accurately reflect the flu vaccine was given facility and section P to reflect the find a Chair and/or Bed alarm. Incident & Accident form was for this incident. Resident #70 has had their me MDS modified to accurately O to reflect the influenza vacquiven outside the facility. A Incident & Accident form we for this incident. Resident #50 has had their me MDS modified to accurately M to accurately reflect a staingury and section O to reflect of the influenza vaccine. A Incident & Accident form we for this incident. Identification of Deficient and Corrective Action(s). All other residents may have been affected. A 100% audresidents current MDS associated by the MDS and/or designee to ensure J, K, N, O, P of the MDS correctly. All negative find reported to the MDS depairmediate correction. A will be completed for eacidentified on the most current for the	code O to ven outside effect the use A facility us completed oost recent code section ceine was facility as completed most recent y code section ge II pressure ect her refusal facility was completed t Practice(s) : ve potentially dit of all essments will coordinator that sections I, s are coded adings will be artment for Modification ch discrepancy	

(resident assessment instrument) manual aspirin

and clopidogrel (plavix) are antiplatelet medications and were not to be coded as

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	107	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495234	B. WING		C 04/12/2018
NAME OF PI	ROVIDER OR SUPPLIER	· * 		STREET ADDRESS, CITY, STATE, ZIP CODE	
				580 DANIEL SMITH ROAD	
HERITAGI	E HALL VIRGINIA BEA	СН		/IRGINIA BEACH, VA 23462	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION
F 641	anticoagulant medic When reviewing the was able to find evi 12/02/17 and anoth On 04/11/18 at app surveyor spoke with regarding the flu va the surveyor that th sent to the family a completed and it ha facility. So, the MD DON stated a corre The administrative regarding the MDS with the survey tea No further informat provided to the sur conference. 3. For Resident #4 coded the Residen assessment in reg The clinical record #46 had been adm Diagnoses include	enursing notes the surveyor dence of two falls one on er on 01/11/18. roximately 8:20 a.m., the n DON (director of nursing) occine. The DON verbalized to e flu vaccine information was not at the time the MDS was ad not been returned to the S was coded incorrectly. The ection had been completed. staff were notified of the issue assessment during a meeting m on 04/12/18 at 3:12 p.m. ion regarding this issue was vey team prior to the exit 6, the facility inaccurately its MDS (minimum data set)	F 641	16004	ons of PS's and Sewed It to of Seed calendar egative eported of on. seed to the onthly acility e.
	depression, gener diabetes. Section C (cogniting quarterly MDS ass (assessment refer a BIMS (brief inter	alized anxiety disorder, and we patterns) of the Residents sessment with an ARD ence date) of 03/02/18 included view for mental status) 12 out of a possible 15 points.			

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F 641 Continued From page 6 Section N (medications) had been coded to indicate the Residents and received insulin injections for 3 out of the last 7 days. A review of the Residents eMARs (electronic medication administration records) revealed that the Resident had received insulin for 7 of 7 the days coded on the MDS assessment. On 4/10/18 at approximately 12:10 p.m., the surveyor and the MDS coordinator reviewed the Residents MDS assessment and eMARs. After this review the MDS coordinator verbalized to the surveyor that the MDS had been miscoded in regards to insulin injections. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #85, the facility staff to accurately code the Residents MDS (minimum data set) assessment in regards to the Residents discharge from the facility. The record review revealed that Resident #85 had been admitted to the facility 02/16/18 and was discharged to an acute care hospital on 02/20/18. Diagnoses included, but were not limited to, atrial			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S0 660	IPLE CONSTRUCTION NG	0	E SURVEY APLETED C 4/12/2018
FREETX TAG FREGULATORY OR LSC IDEMPIFYING INFORMATION) F 641 Continued From page 6 Section N (medications) had been coded to indicate the Resident had received insulin injections for 3 out of the last 7 days. A review of the Residents eMARs (electronic medication administration records) revealed that the Resident had received insulin for 7 of 7 the days coded on the MDS assessment. On 4/10/18 at approximately 12:10 p.m., the surveyor and the MDS coordinator reviewed the Residents MDS assessment and eMARs. After this review the MDS coordinator reviewed in regards to insulin injections. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #85, the facility staff to accurately code the Residents MDS (minimum data set) assessment in regards to the Residents discharge from the facility. The record review revealed that Resident #85 had been admitted to the facility 02/16/18 and was discharged to an acute care hospital on 02/20/18. Diagnoses included, but were not limited to, atrial	SANTAGORAGO AT S	ME OF PROVIDER OR SUPPLIER ERITAGE HALL VIRGINIA BEACH X4) ID REFTIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 641 Continued From page 6 Section N (medications) had been coded to indicate the Resident had received insulin injections for 3 out of the last 7 days. A review of the Residents eMARs (electronic medication administration records) revealed that the Resident had received insulin for 7 of 7 the days coded on the MDS assessment. On 4/10/18 at approximately 12:10 p.m., the surveyor and the MDS coordinator reviewed the Residents MDS assessment and eMARs. After this review the MDS coordinator verbalized to the surveyor that the MDS had been miscoded in regards to insulin injections. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #85, the facility staff to accurately code the Residents MDS (minimum data set) assessment in regards to the Residents discharge from the facility. The record review revealed that Resident #85 had been admitted to the facility 02/16/18 and was discharged to an acute care hospital on 02/20/18. Diagnoses included, but were not limited to, atrial fibrillation, coronary artery disease, chronic	ŝ	5580 DANIEL SMITH ROAD	DE		
Section N (medications) had been coded to indicate the Resident had received insulin injections for 3 out of the last 7 days. A review of the Residents eMARs (electronic medication administration records) revealed that the Resident had received insulin for 7 of 7 the days coded on the MDS assessment. On 4/10/18 at approximately 12:10 p.m., the surveyor and the MDS coordinator reviewed the Residents MDS assessment and eMARs. After this review the MDS coordinator verbalized to the surveyor that the MDS had been miscoded in regards to insulin injections. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #85, the facility staff to accurately code the Residents MDS (minimum data set) assessment in regards to the Residents discharge from the facility. The record review revealed that Resident #85 had been admitted to the facility 02/16/18 and was discharged to an acute care hospital on 02/20/18. Diagnoses included, but were not limited to, atrial	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
obstructive pulmonary disease, and hypertension Section C (cognitive patterns) of the Residents	F 641	Section N (medicati indicate the Resider injections for 3 out of the Resident provided injections for 3 out of the Resident had reduced a section administs the Resident had reduced a surveyor and the M Residents MDS as this review the MDS surveyor that the M regards to insulin in the administrative regarding the MDS with the survey teath to further informat provided to the surconference. 4. For Resident #8 code the Resident assessment in regulational discharge from the The record review had been admitted was discharged to 02/20/18. Diagnoses include fibrillation, coronar obstructive pulmon the record review and the record review had been admitted was discharged to 02/20/18.	ons) had been coded to an thad received insulin of the last 7 days. idents eMARs (electronic tration records) revealed that eceived insulin for 7 of 7 the MDS assessment. Eximately 12:10 p.m., the IDS coordinator reviewed the sessment and eMARs. After a coordinator verbalized to the IDS had been miscoded in elections. Staff were notified of the issue assessment during a meeting m on 04/12/18 at 3:12 p.m. ion regarding this issue was every team prior to the exit 5, the facility staff to accurately ands to the Residents elecility. revealed that Resident #85 at to the facility 02/16/18 and an acute care hospital on electronic mary disease, and hypertension in the stage of the stage	F	641		

Event ID: YZN011

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
495234 B.	. WNG_		04/12/201	a
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COMPL	.5) LETION ITE
Continued From page 7 discharge MDS assessment with an ARD (assessment reference date) of 02/20/18 included a BIMS (brief interview for mental status) summary score of 0 out of a possible 15 points and had been coded to indicate the Resident had been discharged to the community. The discharge summary signed by the physician (02/22/18) revealed that Resident #85's discharge diagnosis was septic shock and he had been admitted to an ICU (intensive care unit). On 04/12/18 at 10:38 a.m., the surveyor reviewed this MDS with the MDS coordinator. After reviewing this MDS, the MDS coordinator verbalized to the surveyor that it had been coded inaccurately. The administrative staff were notified of the issue regarding the MDS assessment during a meeting with the survey team on 04/12/18 at 3:12 p.m. Prior to the exit conference the MDS coordinator provided the surveyor with a corrected copy of the MDS indicating the Resident had been discharged to an acute hospital. No further information regarding this issue was provided to the survey team prior to the exit conference. 5. The facility staff failed to maintain an accurate MDS (Minimum Data Set) assessment for Resident #76. Resident #76 was readmitted to the facility on 2/14/18 with the following diagnoses of, but not limited to anemia, high blood pressure, dementia, seizure disorder and depression.	F 6	341		

PRINTED: 05/04/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	IPLE CONSTRUCTION			E SURVEY PLETED C
2000		495234	B. WING			04	V12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEA	сн	1 1 7 1	STREET ADDRESS, 5580 DANIEL SMIT VIRGINIA BEACH			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH	OVIDER'S PLAN OF CORREC' I CORRECTIVE ACTION SHOU REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 641	On the significant of Set) with an ARD (of 2/26/18; the resishort term and long moderately impaired Resident #76 was dependent on 1 strategies contained by the surveyor performance with the follow management of the surveyor performance with the follow management of the surveyor performance with the follow management of the surveyor performance with the surveyor of the surveyor of the surveyor notion of the MDS nursed should be coded or resident with a an of the MDS nursed and get back to you will be surveyor notion of the surveyor notion of the surveyor of the surveyo	change MDS (Minimum Data Assessment Reference Date) dent was coded as having g-term memory loss and being ed in making daily decisions. also coded as being totally aff member for dressing, and bathing. ormed a review of Resident ed on 4/10/18. During this ed by the surveyor that Resident eing physician order: ar clip alarm while in bed and in " The resident's care plan was te of "12/26" which had the alarms as ordered" for the for falls with injury" The eth ARD of 2/26/18 coded the ction P, P0200, Alarms, as a "0" alarms being used. Proximately 2 pm, the surveyor eff if bed and chair alarms on Resident #76 when the reder as documented above. Et stated, "I will have to check ou on this." fied the administrative team of ented findings on 4/10/18 at 5 am, the surveyor was provided rected MDS with bed and chair ed as "2" which means that the	F	641			

Event ID: YZN011

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	85-26024360	LETED
		495234	B. WING				12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н		5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD SINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 641	Continued From pag	e 9	F	641			
	MDS (Minimum Data Resident #79. Resident #79 was re 3/12/18 with the folid limited to high blood depression and Chro Disease. On the MDS (Minim (Assessment Refere resident was coded Interview for Mental possible score of 15 coded as requiring emember for dressing being totally dependently bathing. The surveyor went 4/11/18 at approxim	ailed to maintain an accurate a Set) assessment for admitted to the facility on owing diagnoses of, but not pressure, diabetes, stroke, onic Obstructive Pulmonary aum Data Set) with an ARD ence Date) of 3/24/18, the as having a BIMS (Brief Status) score of 5 out of a sextensive assistance of 1 staffing and personal care and dent on 1 staff member for attely 11:30 am. The surveyor part to be citting up in his					
	observed the reside wheelchair with a la resident's waist to to the resident's representation of the time this surveyor asked the could until the lap stated in a whisper that way so that he The surveyor asked the lap belt that way looked puzzled as asked him to do. T	ent to be sitting up in his up belt tied around the he back of the wheelchair. esentative was also in the sobservation was made. The representative if the resident belt. The representative, "He can't get to it. It's done can't wander off anymore." It wander off anymore." It he resident if he could undo so around his waist and he to what the surveyor had the resident did not respond to					
	the surveyor. The surveyor perfo	rmed a review of Resident	10000	27.5			

PRINTED: 05/04/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A, BUILD	TIPLE CONS	TRUCTION		SURVEY PLETED
		495234	B. WNG				C /12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEA	сн		5580 DA	ADDRESS, CITY, STATE, ZIP CODE ANIEL SMITH ROAD IIA BEACH, VA 23462	1 04	712/2013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	1015H	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 641	#79's clinical record review, the surveyor of 3/24/18, docume under Section K, as same MDS, the resuse of a restraint, usurveyor reviewed electronic clinical redocumented on 3/1 At 3:15 pm, the sur #1 of the above do On 4/11/18 at 5:15 administrative team findings of the inco. The surveyor was corrected MDS who documented as 15 had a trunk restrain used daily. These conference room to the facility on 4/10. No further information surveyor prior to the facility on 4/10. No further information surveyor prior to the facility on 4/10. Resident #30 was 08/08/16. Diagnos anemia, thrombood dementia, depress chronic obstructive dysphagia, and os The most recent Man ARD (assessment).	d on 4/11/18. During this or noted on the MDS with ARD ented the resident's weight, as 50 pounds. Also on the sident was not coded for the under Section P, P0100. The the vital signs tab in the ecord and the weight 12/18 was 150.2 pounds. It weight a surveyor notified the MDS nurse cumented findings. pm, the surveyor notified the most the above documented irrect weight on the MDS. It provided copies of the inch had the resident's weight 4 pounds in Section K and also and coded in Section P as being copies were left lying on the able when the surveyor arrived 12/18 at 7:45 am. It ion was provided to the ne exit conference on 4/12/18. Of the facility staff failed to code from I of the MDS. admitted to the facility on the sincluded but not limited to sytopenia, hyperlipidemia, sion, insomnia, tachycardia, as pulmonary disease,	F	641			

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
		495234	B. WNG		0	4/12/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH				STREET ADDRESS, CITY, STATE, ZIP C 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	0.0000		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	iD PREFI TAG		ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 641	diagnoses as departured diagnoses as departured diagnoses as departured discussed with the meeting on 04/10/18 at approphysician's order as dysphagia, chromod disorder. The surveyor required diagnosis list for listed as thrombounspecified demark disturbance, major recurrent, mild, in obstructive pulmor resp info (respiration of the surveyor specified demark disturbance, major recurrent, mild, in obstructive pulmor resp info (respiration of the surveyor specified demark disturbance, major recurrent, mild, in obstructive pulmor resp info (respiration of the surveyor specified demark discussed with the concern of the concern of the discussed with the meeting on 04/10/18 at approximation of the concern of the concern of the concern of the discussed with the meeting on 04/10/18 at approximation of the concern	age 11 ection I of the MDS listed ression and asthma. This is a nical record was reviewed on ximately 1000. It contained a summary for the month of April, "Memantine HCI 10mg tablet- 1 nes a day dx (diagnosis) ricept 10 mg tablet PO (by e Dx: dementia". The summary had diagnoses listed onic obstructive pulmonary cytopenia, hyperlipidemia, and rested and was provided with a Resident #30. Diagnoses were cytopenia, hyperlipidemia, entia without behavioral or depressive disorder, somnia, unspecified, chronic mary disease w acute lower cory infection), and dysphagia. Reke with MDS coordinator on eximately 1030 regarding tagnoses. Surveyor asked MDS effically if the diagnosis of have been coded on the MDS, mator stated that it should have. The inaccurate MDS was the administrative team during a 10/18 at approximately 1655. The inaccurate MDS was the administrative team during a 10/18 at approximately 1655.	F	641			
6	8. For Resident	#41 the facility staff failed to code					

	MENT OF DEFICIENCIES LAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234		(X2) MULTIPLE CO	DNSTRUCTION	C 04/12/2018		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 641	Diagnoses included obesity, spinal steno pulmonary disease, heart failure, sleep a depression. The most recent MD an ARD (assessmer coded the Resident cognitive status. Set this MDS listed diag asthma with addition obesity, spinal steno weakness. This is a The Resident's clini 04/11/18. It contains summary for the mouth) daily -CHF ("Lisinopril 10 mg ta (every day), DX (dia (hypertension)". Dia order summary wer morbid obesity, arth hypokalemia, acute	dmitted to the facility on but not limited to morbid sis, chronic obstructive hypokalemia, congestive apnea, hypertension, and as (minimum data set) with at reference date) of 02/16/18 as 15 of 15 in section C, ction I, active diagnoses, of noses as depression and hal diagnoses listed as morbid osis, spondylosis and muscle quarterly MDS. cal record was reviewed on ed a physician's order onth of April, which read in my tablet 1 tab PO (by (congestive heart failure)* and blet-take one tab PO QD	F 641				
	04/12/18 at approx Resident #41's MD coordinator should physician's order s	th MDS coordinator on imately 0935 regarding 0S. Surveyor asked MDS the diagnoses listed on the number of the coded on the MDS of the stated "Let me investigate of".					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			C C	
	9796.55 (PAN)	495234	B. WING_			04/12/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH				5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD SINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLETION	
F 641	Continued From p		F	641			
	coordinator provid section I of the Re asthma with additi obesity, spinal ste weakness and sta correction. The did MDS were depres diagnoses listed a stenosis, spondyld was the same as The concern of the with the administre 04/12/18 at approvided in the section O (Special Programs) and Section O (Special Programs) and Section I of the Rection O (Special Programs) and Section I of the Rection O (Special Programs) and Section I of the Rection O (Special Programs) and Section I of the Rection O (Special Programs) and Section I of the Rection O (Special Programs) and Section I of the Rection I of t	e incorrect MDS was discussed ative team during a meeting on ximately 1510. ation was provided prior to exit. If failed to accurately code al Treatment, Procedures, and ection P (Restraints) on uarterly minimum data set					
	The clinical recort 4/9/18 through 4/9 admitted to the fathat included but disease, dementionally major depressive thrive, and history (MDS) assessment reference date (Aresident with long short-term memory impaired cognitive.	d of Resident #48 was reviewed 12/18. Resident #48 was acility 11/28/17 with diagnoses, not limited to Alzheimer's a with behavioral disturbances, disorder, anxiety, adult failure to					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234		A, BUILDI	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			B. WING	5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD SINIA BEACH, VA 23462	04/12/2018			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE A REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	CTION SHOULD BE COM	
F 641	behaviors. (a) The facility staff of Section O Special To Programs on Reside Section O Special To Programs was revied (00250 A, B, and Coread "Did the reside vaccine in this facility vaccination season answered "No" with 00250C, If influence reason. Section Conformation about the kept with the director The surveyor requer Resident #48's influenced administered. The Resident #48 documents of the surveyor requeration of the Resident #48 documents of the	failed to accurately code reatment, Procedures, and ent #48's quarterly MDS. reatment, Procedures, and wed. Influenza Vaccine) was reviewed. Section A not receive the influenza cy for this year's influenza cy. The question was instructions to skip to a vaccine not received, state was marked "5. Not offered." he influenza vaccinations were or of nurses. sted information when lenza vaccination had been "Immunization List" for mented the resident had the on on 10/1/17 prior to	F	641					
	in this facility during vaccination season outside of this facili contraindication 4. offered. 6. Inability due to a declared sabove."	also included: 1. Resident not g this year's influenza general to 2. Resident received ty. 3. Not eligible-medical Offered and declined. 5. Not y to obtain influenza vaccine shortage. 9. None of the oved the influenza vaccination ty; therefore, option 2 should							
	have been marked The surveyor inten (MDS) assessmen	/coded. viewed minimum data set t licensed practical nurse #1 on #1 stated the information in		200					

7.5 to 1 - 2 - 1 - 2 - 2 - 2 - 2 - 2 - 2 - 2 -		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
	200	495234	B. WING			04	/12/2018	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 641		influenza vaccination was	F	641				
	(b). The facility staff	a correction would be done. failed to accurately code on Resident #48's quarterly 5/18.						
	2018 physician's ord 12/5/17 that resident all times for safety. Restraints and speci have any type of ala	ember 2017 through April er sheets had an order dated was to wear a clip alarm at A review of Section P ffically P0200 Alarms did not rm coded-bed, chair, floor wander/elopement, and						
	morning of 4/10/18 a back wheelchair in t attached from the ba resident's clothing. practical nurse #1 cl	serve Resident #48 on the at 8:53 a.m. sitting in a high he TV area with a clip alarm ack of the wheelchair to the The unit manager licensed hecked the alarm to ensure and the alarm sounded						
	(MDS) licensed practices 3:53 p.m. regarding on the MDS. MDS/documentation in the support the coding.	iewed the minimum data set ctical nurse #1 on 4/10/18 at g the coding of the clip alarm LPN #1 stated she had no se 7-day look back period to for the alarms. MDS/LPN #1 of the quarterly MDS would be						
	director of nursing of Resident #48's qua day meeting on 4/1	ned the administrator and the of the inaccurate coding on rterly MDS in the end of the 0/18 at 4:55 p.m., again on and on 4/12/18 at 3:12 p.m.						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A CONTROL OF THE PARTY OF THE P	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495234	B. WING		C 04/12/2018		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STREET ADDRESS, CITY, STATE, ZIP CO 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 641	Continued From pag	e 16	F6	41			
	No further informatio exit conference on 4.	n was provided prior to the /12/18.					
	Section O Special Tr Programs on Reside data set (MDS) asse reference date (ARD MDS with an ARD of The clinical record of 4/9/18 through 4/12/19 admitted to the facility included but not limity bradycardia, hypokate enterocolitis due to of disorder, chronic ob- hyperlipidemia, pulna Takotsubo syndromice esophagus, left venta chronic systolic hear	failed to accurately code eatments, Procedures and int #70's admission minimum issment with assessment b) of 2/26/18 and the 14 day if 3/3/18. If Resident #70 was reviewed 18. Resident #70 was by 2/19/18 with diagnoses that ted to atrial fibrillation, llemia, long QT syndrome, Clostridium difficle, anxiety istructive pulmonary disease, monary hypertension, ie, diverticulum of the incular failure, acute on it failure, and anorexia.					
	resident with a brief a 15. The "Resident Immu#70 documented the influenza vaccinatio daughter (dated 3/8 on the 5-day and 14 1. 1 read "Resident year's influenza vaccination days and 14 1. 1 read "Resident year's influenza vaccination days at 11:22 influenza season w	unization Record" for Resident at the resident received the n on 12/17/17 per the //18). A review of Section O day MDS was coded with a thot in this facility during this					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION UILDING		(X3) DATE SURVEY COMPLETED	
		405224	D MANG			С	
NAME OF P	ROVIDER OR SUPPLIER	495234	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO		4/12/2018	
HERITAGE HALL VIRGINIA BEACH				5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	, SC		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 641	assessment license 4/10/18 at 1:59 p.m Section O on the 5-MDS/LPN #1 stated ends in December 2 evidence of flu during 3/8/18. Will do mod The surveyor inform director of nursing during the end of th 4:55 p.m., 4/11/18 at 4/12/18 at 3:15 p.m No further informati exit conference on 11. The facility staff Section M and M	iewed the minimum data set ed practical nurse #1 on a regarding the coding of day and 14 day MDS. If, "I'll modify it. Flu season 2017. Daughter broughting a care plan meeting on ifications." The deterministrator and the post of the above coding issue are day meeting on 4/10/18 at at 5:15 p.m. and again on a consumer of the above coding issue are foundations.	F	541	0		
	limited to hemipleg accident affecting a thrive, B12 nutrition communication def adrenocortical insu hypertension, nonthypothyroidism, bill hypoxia, dementia,	ia following cerebral vascular unspecified side, adult failure to nal deficiency, cognitive ficit, depressive disorder, fficiency, aphasia, oxic multinodal goiter, ateral deep vein thrombosis,					

PRINTED: 05/04/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING_ C 495234 B. WNG 04/12/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD HERITAGE HALL VIRGINIA BEACH

HEIGHAGE	E HALL VIRGINIA BEACH	VIRGINIA BEACH, VA 23462				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION E DATE		
F 641	Continued From page 18	F 64	1			
F 641	continued From page 18 assessment with an assessment reference date (ARD) of 3/7/18 assessed the resident with short-term memory problems, long-term memory problems and moderately impaired cognitive skills for daily decision making. No indicators of delirium, behaviors or psychosis. (a). The facility failed to accurately code a stage 2 pressure ulcer in Section M Skin Conditions on the 60 day MDS with ARD of 3/7/18. The surveyor reviewed the wound care doctor's progress note dated 2/28/18. The note read "Pressure Wound of the Right Heel pressure stage 2 duration greater than 1 day, healing, manage pain and Pressure Ulcer sacrum pressure stage 2 duration greater than 1 day, healing manage pain." Section M Skin Conditions and specifically Section M0150 Risk of Pressure Ulcers was coded resident was at risk of developing pressure ulcers. M0210 Unhealed pressure ulcer(s) was coded with a "0"-does this resident have one or more unhealed pressure ulcer (s) at stage 1 or higher. The code was 0 with instructions to skip to M0900, Healed Pressure Ulcers. The surveyor interviewed the minimum data set (MDS) assessment licensed practical nurse #1 on 4/12/18. MDS/LPN #1 stated the area was coded as moisture associated skin damage. MDS/LPN #1 stated she would do a correction as Section M was not accurately coded. (b). The facility failed to accurately code the influenza vaccine in Section O Special	F 64				
	Treatments, Procedures and Programs. Section O Special Treatments, Procedures and	!				
FORM CMS-25	67(02-99) Previous Versions Obsolete Event ID:YZN011		Facility ID: VA0118 If continue	ation sheet Page 19 of 90		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495234	B. WING	200		04/12	2/2018
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			5580	EET ADDRESS, CITY, STATE, ZIP CODE DIDANIEL SMITH ROAD GINIA BEACH, VA 23462	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	10000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 641	Influenza Vaccine waskip to O0250C, If i state reason. Sectioffered. The surveyor was used record for Resident discharge summary discharge dated 12 summary read "Influenced". Section C options a in this facility during vaccination season outside of this facility during vaccination season outside of this facility due to a declared above." The surveyor interfaction 4. The surveyor interfaction of the surveyor information of the surveyor informat	ewed. Section O0250 vas coded 0 and instructions to influenza vaccine not received, on C was coded "5"-not unable to locate immunization #50. The facility provided the vector from Resident #50's /5/17. The discharge uenza Vaccine-Patient also included: 1. Resident not g this year's influenza i. 2. Resident received ity. 3. Not eligible-medical i. Offered and declined. 5. Not y to obtain influenza vaccine shortage. 9. None of the viewed MDS/LPN on 4/11/18 at g coding for the influenza N #1 stated she would correct med the administrator, the , and the corporate registered if the day meeting on 4/11/18 at in on 4/12/18 at 3:15 p.m. attion was provided prior to the in 4/12/18.		641			
SS=	S483.21 Compreh	nensive Person-Centered Care		BETAVA ATAMA IS TAVA		3	

PRINTED: 05/04/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		495234	B. WNG				04/12/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH				558	EET ADDRESS, CITY, STATE, ZIP CODE 0 DANIEL SMITH ROAD 2 GINIA BEACH, VA 23462	1 04/122010		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	0.000	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 655	Planning §483.21(a) Baseli §483.21(a)(1) The implement a base that includes the i effective and pers that meet profess. The baseline care (i) Be developed admission. (ii) Include the min necessary to propincluding, but not (A) Initial goals be (B) Physician ord (C) Dietary orders (D) Therapy service (F) PASARR recomprehensive of care plan if the care plan if t	ne Care Plans a facility must develop and line care plan for each resident instructions needed to provide con-centered care of the resident ional standards of quality care. Is plan must- within 48 hours of a resident's minum healthcare information cerly care for a resident limited to- ased on admission orders. In the facility may develop a are plan in place of the baseline comprehensive care plan- within 48 hours of the resident's uirements set forth in paragraph in (excepting paragraph (b)(2)(i) of the facility must provide the in representative with a summary are plan that includes but is not als of the resident. If the resident's medications and	F	655	Corrective Action(s): Resident #65. #67. #76, #184, #79, # #70, #134. #136. #45, #234 and #284 attending physicians and RP's were notified that the facility failed to pro- written summary of their base line ca- plan to the residents or their RP's at a time of admission. Identification of Deficient Practice & Corrective Action(s): All newly admitted residents may ha potentially been affected. A 100% re of all new admissions in the last 30 c will be conducted by the DON, RCC and/or designee to identify residents did not receive a written summary of baseline comprehensive care plan Al residents and RP's identified that did received a written summary of their baseline comprehensive care plan w have their care plan reviewed and up and a written summary of their resid centered care plan will be reviewed given to the Residents and RP's identified. A Facility Incident & Act Form will be completed for each incidentified.	vide a are the s ve view days their ill dated ent and cident		

Facility ID: VA0118

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200.00000000000000000000000000000000000	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495234	B. WNG		C 04/12/2018	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL 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	
F 655	on behalf of the factive Any updated in of the comprehens. This REQUIREME by: Based on staff interview, the facility resident and/or the summary of the baresidents in the summary of the baresident was and representative baseline care plan. Resident #65 was 12/22/17 with the summary of th	formation based on the details ive care plan, as necessary. NT is not met as evidenced erview and clinical record staff failed to provide the eir representative with a eseline care plan for 12 of 25 curvey sample (Resident #65, 79, #50, #70, #134, #136, #45, ded:	F 655	Systemic Changes: The facility Policy and Procedure been reviewed and no changes ar warranted at this time. The nursir assessment process as evidenced 24 Hours Report and documentat the medical record and physician will be used to develop and revis line care plans within 48 hours of admission to the facility and a wisummary will be given to the Resand RP. The RCC and IDT will be inserviced by the regional nurse consultant on the development are of the baseline as well as the proreviewing the base line care plan residents and RP's. Monitoring: The RCC and DON are responsificationing compliance. The DC RCC will perform care plan audinew admissions 48 hours after act to ensure a base line care plan had completed timely and that a writt summary has been completed an reviewed with the resident and/of Any/all negative findings will be to the RCC for immediate correct Detailed findings of the Care Plawill be reported to the Quality A Committee for review, analysis, recommendations for change in policy, procedure, and/or practic Completion Date: May 25, 201	by the cition in orders e base fritten sident or orders with ble for DN and/or its on all dmission as been ten ten ten ten ten ten ten ten ten	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495234	B. WING		C 04/12/2018	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			55	REET ADDRESS, CITY, STATE, ZIP CODE 80 DANIEL SMITH ROAD RGINIA BEACH, VA 23462) 04/12/2010	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION	
F 655	readmitted to the factor surveyor notified MD documented findings MDS nurse #1 stated had been doing them. The surveyor notified the above document 3:12 pm. No further information surveyor prior to the 2. The facility failed to representative with a care plan for Reside Resident #67 was read 1/10/18 with the folic limited to anemia, he pressure, Alzheimer Parkinson's disease depression, manic of Obstructive Pulmona (Minimum Data Set) Reference Date) of with a BIMS (Brief In score of 15 out of a Resident #67 was a assistance of 1 staff extensive assistance personal hygiene. Fas being totally depot bathing. The surveyor perfor on Resident #67 on surveyor that no documents with a present that the surveyor perfor on Resident #67 on surveyor that no documents with a present that the surveyor that no documents with a present that the surveyor that no documents with a present that the surveyor that no documents with a present that the surveyor perfor on Resident #67 on surveyor that no documents with a surveyor performance with the surveyor perf	ility on 12/22/17. The S nurse #1 of the above on 4/12/18 at 2 pm. The d, ""I didn't know that I should n." If the administrative team of ed findings on 4/12/18 at In was provided to the exit conference on 4/12/18. It oprovide the resident and a summary of the baseline at #67. It admitted to the facility on the swing diagnoses of, but not eart failure, high blood is disease, dementia,	F 655			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED C	
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	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	Н		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 655	representative when to the facility on 1/10 interview conducted 9:57 am, the residen surveyor if she was gare plan when she in January, "I don't retain January, "I don't r	the resident was readmitted /18. During the resident by the surveyor on 4/10/18 at a stated when asked by the given a copy of the baseline was readmitted to the facility emember." If MDS nurse #1 of the above of on 4/10/18 at approximately erence room. The MDS idn't know that I should had was notified of the change by understand it at the time." If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings. If the administrative team on and on 4/12/18 at 3:12 pm of the findings.	F 658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII		NSTRUCTION	COM	E SURVEY IPLETED	
spectroscoper o		495234	B. WING			0-	1/12/2018
	ROVIDER OR SUPPLIER HALL VIRGINIA BEA	СН		5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD IINIA BEACH, VA 23462		
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F 655	Continued From pa	ge 24	F	655			
	#76's clinical record clinical record revisany documentation was given to the rethe time of readmis. The surveyor notification of the time of readmis. The surveyor notification of the conurse #1 stated, "I been doing them. but I didn't thoroug. The surveyor notification of the surveyor notification of the above documents. No further information surveyor prior to the above documents. A. The facility failed representative with care plan for Resident #184 was 4/6/18 with the follimited to sepsis, related to C-Diff, high blood pressurvey in the nurse admission nursing was documented oriented. It was a #184 requires extending the total requirements.	tion was provided to the ne exit conference on 4/12/18. In the distribution of the di					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	97 25	IPLE CONSTRUCTION		E SURVEY PLETED C	
		495234 B. WNG			04/12/2018		
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н		STREET ADDRESS, CITY, STATE, ZIP 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	iD PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 655	surveyor on 4/11 and there was no docum plan being given to the representative when the facility on 4/6/18. The surveyor had primary of the surveyor had primary on the facility on 4/10/18 at approximate the surveyor plans and representative work or readmitted to the nurse #1 stated, "I didn't thorough the surveyor notifier 4/12/18 at 3:12 pm of findings. No further informations are very prior to the surveyor prior	cord review performed by the d 4/12/18, it was noted that entation of the baseline care he resident and the resident was admitted to	F	655			
	care plan for Reside	eadmitted to the facility on	i				
	limited to high blood depression and Ch Disease. On the M an ARD (Assessment the resident was co Interview for Menta	owing diagnoses of, but not dipressure, diabetes, stroke, ronic Obstructive Pulmonary DS (Minimum Data Set) with ent Reference Date) of 3/24/18 oded as having a BIMS (Brief Il Status) score of 5 out of a 5. The resident was also					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION			E SURVEY PLETED C
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NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH (X4) ID SUMMARY STATEMENT OF DEFICIENCIES							
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EAC	ROVIDER'S PLAN OF CORREC CH CORRECTIVE ACTION SHOT S-REFERENCED TO THE APPR DEFICIENCY)	ULD BÉ	(X5) COMPLETION DATE
F 655	member for dressing being totally deperbathing. The surveyor performance of the surveyor performance of the was no documented being given to the when the resident on 3/12/18. The surveyor had #1 on 4/10/18 at a conference room of baseline care plan and representative or readmitted to the nurse #1 stated, "been doing them. but I didn't thorouse the surveyor notification of the surveyor prior to the surveyor prior to the facility state or Resident #70's the baseline care.	extensive assistance of 1 staffing and personal care and indent on 1 staff member for some a review of Resident of on 4/11/18. During this ad by the surveyor that there ation of the baseline care plan resident and representative was readmitted to the facility previously notified MDS nurse approximately 11:15 am in the of no documentation concerning as being given to the resident ewhen a resident was admitted the facility. At that time the MDS I didn't know that I should had I was notified of the change ghly understand it at the time." If the administrative team on the of the above documented ation was provided to the the exit conference on 4/12/18. If failed to provide Resident #70 is representative with a copy of	F	655			
	admitted to the fa included but not l bradycardia, hype	icility 2/19/18 with diagnoses that imited to atrial fibrillation, okalemia, long QT syndrome, to Clostridium difficle, anxiety					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION	
F 655	hyperlipidemia, pulm Takotsubo syndrome esophagus, left vent chronic systolic hear Both the 5 day and 1 resident with a brief a 15. The surveyor intervided/10/18 at 11:00 a.m resident if the facility admission or baselind didn't recall getting of the surveyor intervided/10/18. MDS/LPN any baseline care plastated she had hear not read about it tho The surveyor inform director of nursing of the end of the day in p.m. and again on 4. No further information exit conference on 4.	structive pulmonary disease, conary hypertension, and diverticulum of the ricular failure, acute on the failure, and anorexia. It day MDS coded the interview for mental status as sewed Resident #70 on and the resurveyor asked the regave her a copy of her are care plan. Resident #70 one. The surveyor asked the regave her a copy of her are care plan. Resident #70 one. The surveyor asked the regave her a copy of her are care plan. Resident #70 one. The surveyor asked the regave her a copy of her are care plan. Resident #70 one. The surveyor asked the regave her a copy of her acute plan. Resident #70 one. The surveyor asked the regave her a copy of her acute plan. Resident #70 one. The surveyor asked the regave her a copy of the surveyor asked the acute plan. Resident #70 one. The surveyor asked the regave her a copy of the surveyor asked the acute plan. Resident #70 one. The surveyor asked the regave her a copy of the surveyor asked the acute plan. Resident #70 one. The surveyor asked the regave her a copy of the surveyor asked the regave her a copy of the plant is acute on the surveyor acute on the survey of the surveyor acute on the survey of the surveyor acute on the survey of the	F 655			
:	reviewed 4/9/18 throwas admitted to the	of Resident #134 was ough 4/12/18. Resident #134 facility 6/29/10 and with diagnoses that included				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	ЭН	5	TREET ADDRESS, CITY, STATE, ZIP CODE 580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	•			
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F 655	but not limited to sta amputation due to in chronic non-ambula asthma, hypothyroic hyperlipidemia, glaupulmonary disease, disturbances, hypercardiac pacemaker, retention, and coron Resident #134's 5 c set (MDS) assessman reference date (ARI resident with shortlong-term memory impaired cognitives. The surveyor review comprehensive can the clinical record; I plan was unable to interviewed Reside at 10:47 a.m. The care plan was not gwas readmitted 3/2. The surveyor interviewed MDS) licensed pra 4:56 p.m. MDS/LP baseline care plans. The surveyor inform director of nursing the end of the day p.m. and again on	aftus-post left above the knee infected left knee hardware, ition, osteoarthritis of knee, dism, Alzheimer's disease, icoma, chronic obstructive dementia without behavioral itension, angina pectoris, blindness right eye, urine itension, angina pectoris, blindness right eye, urine itension, and moderate itension minimum data ent with an assessment bloof 4/2/18 assessed the iterm memory problems, itensions, and moderately itensions,	F 655					

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234		8 8		NSTRUCTION	COI	TE SURVEY MPLETED C
September 1990 April 1			D. VVIING			04/12/2018	
5.0	ROVIDER OR SUPPLIER HALL VIRGINIA BEA	СН		5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD INIA BEACH, VA 23462		
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F 655	V-5	failed to provide Resident 136's representative a copy of	F	655			
	record 4/9/18 throu was admitted to the that included but no urinary tract infection pulmonary disease bursitis, morbid obsosteoarthritis, gastrapnea, depressive anemia, and venou	wed Resident #136's clinical gh 4/12/18. Resident #136 is facility 4/1/18 with diagnoses of limited to hypertension, on, chronic obstructive, radiculopathy, trochanteric esity, right artificial hip joint, rointestinal hemorrhage, sleep disorder, iron deficiency is thrombosis and embolus.					
	dated 4/2/18. Instr baseline care plan must be developed admission to the fa must reflect the res preferences and in address his/her cu	contained a baseline care plan uctions at the top of the read "The Baseline Care Plan I within the first 48 hours of ucility. The Baseline Care Plan sident's stated goals and uclude interventions that rrent needs. Complete all les are required as designated."					
	of the resident or to the only signature set licensed praction. The surveyor inter 4/10/18 at 4:00 p.i	plan did not have a signature he resident representative. was that of the minimum data cal nurse #1 and dated 4/3/18. viewed Resident #136 on m. Resident #136 stated she iving a care plan when first					
	The surveyor inter	viewed the minimum data set				89 8	

1.MME OF PROVIDER OR SUPPLER STREET ADDRESS.CITY, STATE_ZIP CODE STREET ADDRESS.CITY, STATE_ZIP CODE STREET ADDRESS.CITY, STATE_ZIP CODE SSED DAMEL SMITH ROAD VIROINA BEACH, VA. 23462 VIROINA BEACH, VA. 23462 VIROINA BEACH, VA. 23462 VIROINA DEPOCIENCY WISTER PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION). 10 PROPUPER PLAN OF CORRECTION PROPERTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCE	STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION			A 120 (10 to 10 to	TE SURVEY MPLETED C	
HERITAGE HALL VIRGINA BEACH (MS)D PREFIX TAG SUMMARY STATEMENT OF DERICIENCIES (EACH DERICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC DERITHYNIA INFORMATION) F 655 Continued From page 30 (MDS) assessment licensed practical nurse #1 on 4/10/18 at 4:56 p.m. MDS/LFN #1 stated she did not complete a baseline care plan on any of the residents. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 7:12 p.m. No further information was provided prior to the exit conference on 4/12/18. 9. The facility staff failed to provide Resident #50 or Resident #50's representative a copy of the baseline care plan. The clinical record of Resident #50 was reviewed 4/9/18 through 4/12/18. Resident #50 was admitted to the facility 5/6/09 and readmitted 1/10/18 with diagnoses that included but not limited to hemiciple following cerebral vascular accident affecting unspecified side, adult failure to thrive, B12 nutritional deficiency, cognitive communication deficit, depressive disorder, adrenocortical insufficiency, aphasia, hypertension, nontoxic multimodal gotter, hypothyroidism, bilateral deep vein thrombosis, hypothysidism, bilateral deep vein thrombosis for daily decision making. No indicators of			495234	B. MNG_		0	4/12/2018
FREEIX TAG REGULATORY OR ISC DENTIFYING INFORMATION) F 655 Continued From page 30 (MDS) assessment licensed practical nurse #1 on 4/10/18 at 4:56 p.m. MDS/LPN #1 stated she did not complete a baseline care plan on any of the residents. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:12 p.m. No further information was provided prior to the exit conference on 4/12/18. 9. The facility staff failed to provide Resident #50 or Resident #50's representative a copy of the baseline care plan. The clinical record of Resident #50 was reviewed 4/9/18 through 4/12/18. Resident #50 was admitted to the facility 5/6/09 and readmitted 1/10/18 with diagnoses that included but not limited to hemiplegia following carebral vascular accident affecting unspecified side, adult failure to thrive, 8.12 nutritional deficiency, cognitive communication deficit, depressive disorder, adrenocortical insufficiency, aphasia, hypertension, nontoxic multimodal gotter, hypothyroidism, bilateral deep vein thrombosis, hypoxia, dementia, and anemia. Resident #50's 60 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/7/18 assessment with an assessment reference date (ARD) of 3/7/18 assessment wind and accident with short-term memory problems, long-term memory problems and moderately impaired cognitive skills for delay decision making. No indicators of			сн		5580 DANIEL SMITH ROAD	CODE	
(MDS) assessment licensed practical nurse #1 on 4/10/18 at 4:56 p.m. MDS/LPN #1 stated she did not complete a baseline care plan on any of the residents. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:12 p.m. No further information was provided prior to the exit conference on 4/12/18. 9. The facility staff failed to provide Resident #50 or Resident #50's representative a copy of the baseline care plan. The clinical record of Resident #50 was reviewed 4/9/18 through 4/12/18. Resident #50 was admitted to the facility 5/5/09 and readmitted 1/10/18 with diagnoses that included but not limited to hemiplegia following cerebral vascular accident affecting unspecified side, adult failure to thrive, B12 nutritional deficiency, cognitive communication deficit, depressive disorder, adrenocortical insufficiency, aphasia, hypertension, nontoxic multinodal goiter, hypothyroidism, bilateral deep vein thrombosis, hypoxia, dementia, and anemia. Resident #50's 60 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/7/18 assessed the resident with short-term memory problems, long-term memory problems and moderately impaired orginitive skills for daily decision making. No indicators of	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACT CROSS-REFERENCED TO	TION SHOULD BE THE APPROPRIATE	COMPLETION
The surveyor reviewed the current	F 655	(MDS) assessment 4/10/18 at 4:56 p.m not complete a bas residents. The surveyor informative of the above p.m. and again on No further informative exit conference on 9. The facility staff or Resident #50's in baseline care plan. The clinical record 4/9/18 through 4/1 admitted to the fact 1/10/18 with diagnoin limited to hemipleg accident affecting thrive, B12 nutrition communication de adrenocortical insulty hypothyroidism, bit hypoxia, dementia. Resident #50's 60 assessment with a (ARD) of 3/7/18 as short-term memor problems and most of daily decision in delirium, behavior	Ilicensed practical nurse #1 on in. MDS/LPN #1 stated she did seline care plan on any of the med the administrator, the and the corporate registered concern on 4/11/18 at 5:15 4/12/18 at 3:12 p.m. it is was provided prior to the 4/12/18. If failed to provide Resident #50 representative a copy of the of Resident #50 was reviewed 2/18. Resident #50 w	F	655		

PRINTED: 05/04/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 495234 B. WING 04/12/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5580 DANIEL SMITH ROAD HERITAGE HALL VIRGINIA BEACH VIRGINIA BEACH, VA 23462 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 655 F 655 Continued From page 31 comprehensive care plan dated 1/10/18. However, the surveyor was unable to locate a copy of the baseline care plan in the clinical record. The surveyor interviewed the minimum data set (MDS) assessment licensed practical nurse #1 on 4/10/18 at 4:56 p.m. MDS/LPN #1 stated she did not complete a baseline care plan on any of the residents. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern on 4/11/18 at 5:15 p.m. and again on 4/12/18 at 3:15 p.m. No further information was provided prior to the exit conference on 4/12/18. 10. For Resident #45, the facility staff failed to provide the Resident and/or representative with a summary of the baseline care plan. The record review revealed that Resident #45 had been admitted to the facility 01/31/18. Diagnoses included, but were not limited to, diabetes, depression, hypertension, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of

possible 15 points.

02/07/18 included a BIMS (brief interview for mental status) summary score of 15 out of a

During an interview with the MDS coordinator on 04/12/18 at approximately 9:25 a.m., the MDS coordinator verbalized to the surveyor that she

had not provided the Resident and/or

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	22 22	IPLE CONSTRUCTION			E SURVEY PLETED C
		495234	B, WING			04	/12/2018
THE PARTY OF THE P	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	эн		STREET ADDRESS, CI 5580 DANIEL SMITH VIRGINIA BEACH,			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH C	VIDER'S PLAN OF CORRECTIVE ACTION SHOUL EFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 655	representative with care plan, as she wito. The administrative sissues regarding the plan on 04/12/18 at No further information provided to the survice of the survice of the summary of the base. 11. For Resident #2 provide the Resider summary of the base. The record review is had been admitted Diagnoses included fibrillation, osteoart and hypertension. There was no MDS assessment inform Resident. During an interview 04/11/18 at approximation of provided the representative with care plan, as she wito. The administrative	as summary of the baseline as not aware that she needed staff was notified of the Residents baseline care approximately 3:12 p.m. on regarding this issue was rey team prior to the exit and/or representative with a seline care plan. The vealed that Resident #234 to the facility 03/28/18. It, but were not limited to, atrial hritis, functional quadriplegia, at (minimum data set) atton completed on this rewith the MDS coordinator on imately 10:35 a.m., the MDS are to the surveyor that she he Resident and/or a summary of the baseline was not aware that she needed staff was notified of the issues dents baseline care plan on	F	655			
		imately 3:12 p.m. ion regarding his issue was					

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234		NG	STRUCTION	(X3) DATE COMP	ETED
3 315202 11	OVIDER OR SUPPLIER HALL VIRGINIA BEAC	100	J. VIII.C	STREE	TADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD INIA BEACH, VA 23462	1 04/	12/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	9400	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDER OF THE	D BE	(X5) COMPLETION DATE
F 655	conference. 12. For Resident #28 provide a written cope Resident #284 was a 04/07/18. Diagnoses cerebral infarction, had the resident was a MDS (minimum data assessed to be alert The surveyor spoke and requested a cope care plan on 04/10/surveyor could not light written summary of provided to the Resident representative. Surveyor spoke with 04/101/8 at approxiproviding a summar MDS coordinator st Resident/represent summary of the car	ey team prior to the exit 34, the facility staff failed to by of the baseline care plan. admitted to the facility sincluded but not limited to hypertension and aphasia. new admit and had not had a set) completed, but was and oriented. with the MDS coordinator by of the Resident's baseline at approximately 0915. The hocate any evidence that a the care plan had been hident or the Resident's in the MDS coordinator on mately 0945 regarding by of the baseline care plan.	F	655			
	The concern of not copy of the baselin	providing the Resident with a e care plan was discussed with eam during a meeting on imately 1655.					
F 657 SS=0	Care Plan Timing a			F 657			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495234	B. WING	B. WNG			C 04/42/2048
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	'	04/12/2018
PERMY PODGETOR PERMANENTAL NEWS	e de productiva e forma de la material de la mater				DANIEL SMITH ROAD		
HERITAGI	E HALL VIRGINIA BEAC	H		VIR	GINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFEP"NCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 657	Continued From pag	e 34	F	657	æ	(8)	
	§483.21(b) Compreh §483.21(b)(2) A combe- (i) Developed within the comprehensive a (ii) Prepared by an ir includes but is not lir (A) The attending ph (B) A registered nurs resident. (C) A nurse aide with resident. (D) A member of foo (E) To the extent prather resident and the An explanation must medical record if the and their resident re not practicable for thresident's care plan. (F) Other appropriat disciplines as determor as requested by t (iii)Reviewed and reteam after each ass comprehensive and assessments. This REQUIREMEN by: Based on staff inter review, the facility sthe Comprehensive for 2 of 25 residents (Resident #67 and #7).	prehensive Care Plans prehensive care plan must 7 days after completion of assessment. Interdisciplinary team, that mited to— aysician. It is with responsibility for the in responsibility for the induction of a resident's representative(s). It is included in a resident's representative is determined in the development of the resident presentative is determined in the development of the included by the resident's needs the resident. It is not met as evidenced wised by the interdisciplinary resident, including both the quarterly review It is not met as evidenced and failed to review and revise Resident Centered Care Plan in the survey sample \$10).		637	F-657 Corrective Action(s): Resident #67's comprehensive of has been reviewed and revised to their current problems, goals and approaches/interventions to mee residents specific medical and recentered needs. A Facility Incide Accident Form was completed frincident. Resident #10's comprehensive of has been reviewed and revised to the use of a divided plate for all Risk Management Incident & A Form was completed for this incident for this incident for the incident of Deficient Pra Corrective Action(s): Any/all residents may have pote been affected. A 100% review of resident comprehensive care plate conducted by the RCC and/or didentify residents at risk. Reside identified at risk as having an incomprehensive care plan will be at time of discovery and a Risk Management Incident & Accide will be completed for each incidentified.	or reflect it the esident ent & or this eares plan o reflect meals. A ccident cident. ctices entially of all ens will be esignee to ents eaccurate e corrected ent Form	
	1. The facility staff f	ailed to review and revise the		ľ			

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH (X4) ID PREFIX TAG Continued From page 35 Comprehensive Resident Centered Care Plan for Resident #67. Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. HERITAGE HALL VIRGINIA BEACH STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462 D PROVIDER'S PLAN OF CORRECTION GEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 657 Systemic Changes: The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of	(X3) DATE SURVEY COMPLETED C	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 657 Continued From page 35 Comprehensive Resident Centered Care Plan for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 657 Systemic Changes: The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care		
Summary statement of Deficiencies (Each Deficiency Must be preceded by Full Regulatory or Lsc Identifying Information) Parkinson's disease, anxiety disorder, done the MDS (Minimum Data Set) with an ARD Parkinson's disease, anxiety disorder, done the MDS (Minimum Data Set) with an ARD Providers plan of correction Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Precision (Fach Correction Should be considered to the interdisciplinary care plan team on the mandate to develop individualized care plan team on the mandate to develop individualized care plan team on the mandate to develop individualized care plan team on the mandate to develop individualized care plan team on the mandate to develop individualized care plan team on the mandate to develop individualized care plan team on	04/12/2018	
CX4) ID PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED FROM IT THE APPROPRIATE PREFIX CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 657 Continued From page 35 Comprehensive Resident Centered Care Plan for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD VIRGINIA BEACH, VA 23462 VIRGINIA BEACH, VA 23462 DID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 657 Systemic Changes: The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the process of the process of the completion of the process of the process of the completion of the process of the process of the process of t		
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 657 Continued From page 35 Comprehensive Resident Centered Care Plan for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 657 Systemic Changes: The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comple		
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 657 Continued From page 35 Comprehensive Resident Centered Care Plan for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, Parkinson's disease, anxiety disorder, depression, manic depression and Chronic Obstructive Pulmonary Disease. On the MDS (Minimum Data Set) with an ARD PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 657 Systemic Changes: The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of		
Comprehensive Resident Centered Care Plan for Resident #67. Resident #67 was readmitted to the facility on 1/10/18 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, Alzheimer's disease, dementia, depression, manic depression and Chronic Obstructive Pulmonary Disease. The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of	(X5) COMPLETION DATE	
(Assessment Reference Date) of 1/22/18 coded the resident with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #67 was also coded as requiring limited assistance of 1 staff member for personal hygiene. Resident #67 was as being totally dependent on 1 staff member for bathing. The surveyor performed a review of Resident #67's clinical record on 4/10 and 4/11/18. During this review, it was noted by the surveyor that on the comprehensive care plan did not have a revise and review date. There were: " "Impaired Vision" with a "Problem Onset" date of 8/12/15 " "Allergic to lodine, Iron salts, Toprol, has intolerance to Ultram, and Remeron, Codeine, Fish" with a 'Problem Onset" of 8/19/14 " "ADL (Activities of Daily Living) rft (related to) inability to maintain ADLs at satisfactory level as evidenced by need of staff assist d/ft (due to) dx. (disease) of Dementia, Pain, Depression,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
						С	
		495234	B. WING	_		04/1	2/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEA C	н			STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE OF THE APPR	BE	(X5) COMPLETION DATE
F 657	8/19/14 " "High risk for incomplete of Blood think Onset" of 8/19/14 The surveyor interview notified her of the absolute of th	with a "Problem Onset" of crease bleeding and bruising agent " with a "Problem onset" of crease bleeding and bruising agent " with a "Problem on the weed MDS nurse #1 and cove documented findings on the MDS nurse #1 stated, "I will of there is another care plan of after this one." on, the surveyor notified the of the above documented of the above documented of the above documented of any more updates or plan for Resident #67. The tated she would look into this surveyor. On was provided to the exit conference on 4/12/18. Failed to review and revise ent comprehensive care plan of the was ordered. Of Resident #10 was reviewed of the time that included but not limited the exit included but not limited on the time that the time that included but not limited on the time that the time t	F	657			
		with an assessment D) of 1/10/18 assessed the					

		IDENTIFICATION NUMBER: A. BUIL		PLE CONSTRUCTION G	СОМЕ	(X3) DATE SURVEY COMPLETED	
		495234	B. WING _		04	/12/2018	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STREET ADDRESS, CITY, STATE, ZIP COD 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 657	long-term memory prindependence for dail The clinical record of physician order dated (patient) to have scort he tray ticket dated under feeding assists. The surveyor observ lunch on 4/10/18 at 1 divided plate. Reside hand eating potatoes. The surveyor review comprehensive care problem identified 7/1 unplanned wt. (weight (diagnoses) dysphagen ausea/vomiting. Application of the diagnoses of the surveyor review recommendations—not supplements as ordered—modeffectiveness, and P. The care plan was norder for the "scoop. The surveyor interviewing stated the scoop pla specialized equipments. The surveyor inform.	rm memory problems, roblems, and modified ily decision-making. Resident #10 had a d 3/12/18 that read "Pt op plate @ (at) meals." 4/11/18 had scoop dish ance devices. ed Resident #10 during 12:14 p.m. The plate was a ent #10 had a fork in the left is. ed the current plan dated 1/12/17. One 5/17 read "At risk for int) loss as evidenced by dx gia, diabetic, PEG tube, oproaches included: Serve (registered dietician) to dical records and make ursing to follow-up, ered, accuchecks as ordered, onitor for side effects and EG tube as ordered. ot revised to include the dish." ewed the minimum data set ares #1 on 4/11/18 at 2:53 g the care plan, MDS/LPN #1 te should be added as	F	157			

	F DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED C			
		495234	B. WING			c	4/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658 SS=D	and again on 4/12/18 No further information exit conference on 4. Services Provided M CFR(s): 483.21(b)(3) §483.21(b)(3) Compound The services provided as outlined by the compound the services provided th	nding on 4/11/18 at 5:15 p.m. B at 3:12 p.m. In was provided prior to the //12/18. Beet Professional Standards (i) In rehensive Care Plans (ii) In rehensive Care Plans (iii) In rehensive		658	F658 Corrective Action(s): Resident #30's attending physibeen notified that the facility sto accurately administer Flonas Spray per physician orders. LP performed the Med Pass observeceived one-on-one inservice the medication administration pracility Incident & Accident Forcompleted for these incidents. Identification of Deficient Practices/Corrective Action(s) All other residents receiving plordered Nasal Sprays may have potentially affected. The DON designee will conduct medicate observations on all resident's rephysician ordered Nasal Spray to identify any residents at risk residents identified at risk will corrected at time of discovery on-one inservice training will provided, an Incident & Accide will be completed for each negfinding. The attending physician order.	aff failed the Nasal N #1 who vation has training on policy. A form was s): hysician the been the and/or tion pass training the medication the All the and One- the	
	an ARD (assessme	DS (minimum data set) with ent reference date) of 02/09/18 t as 15 of 15 in section C, nis is a quarterly MDS.					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234	N A	чG	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/12/2018
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			ST 55	REET ADDRESS, CITY, STATE, ZIP CODE 80 DANIEL SMITH ROAD RGINIA BEACH, VA 23462	1 04/12/2016
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 658	observed LPN #1 (administering Resispray, LPN #1 adm Flonase into each Resident #30's methe clinical record of 0930. The clinical rorder summary, whallergy RLF 50 modaily". The Resider contained an entry allergy RLF 50 modaily". Surveyor spoke whapproximately 093 Flonase. Surveyor sprays of the Flonashe stated 1 in each #1 to pull the order and then stated, "In the surveyor requipractice for admin DON (director of mapproximately 103 of a policy entitled This policy read in Medications shall timely manner, and must be administed orders, including a individual administ check the label Thright Resident, right residen	proximately 0920, surveyor licensed practical nurse) dent #30's Flonase nasal ministered 1 spray of the of Resident #30's nostrils. dications were reconciled with on 04/10/18 at approximately record contained a physician's nich read in part "Flonase g spr 2 sprays in both nares nt's eMAR was reviewed and which read in part "Flonase g spr 2 sprays in both nares of the LPN #1 on 04/10/18 at 5 regarding Resident #30's asked LPN #1 how many ase she had administered and ch nostril. Surveyor asked LPN rand look at it. LPN #1 did so, guess I owe her one". Dested the facility standards of istering medications from the sursing) on 04/10/18 at 85 and was provided with a copy "Administering Medications". It part "Policy Statement be administered in a safe and d as prescribed. 3. Medications ared in accordance with the any required time frame. 7. The tering the medication must HREE (3) times to verify the ht medication, right dosage, at method (route) of	F	658	Systemic Change(s): The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications and treatments per physician order. Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include pre and post administration instructions. Monitoring: The DON is responsible for maintaining compliance. The DON and/or QA Nurse will perform 2 medication pass observations weekly in order to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 25, 2018	y t

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		495234	B. WNG		ه أ	C 4/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEACI	н		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 658	The concern of the in being administered w administrative team of at approximately 165 No further information Quality of Care	e giving the medication." accorrect dose of medication was discussed with the during a meeting on 04/10/18	F 6:			
SS=D	§ 483.25 Quality of control Quality of care is a function of a public to all treatments facility residents. Base assessment of a resident residents receive accordance with proportice, the comprecare plan, and the restrict of the resident of the resident of the resident of the proportion of the resident of the proportion of the resident of the proportion of the proportion of the proportion of the proportion of the physician. Resident #24 was accordance of the physician of the phy	andamental principle that and care provided to sed on the comprehensive ident, the facility must ensure a treatment and care in fessional standards of hensive person-centered esidents' choices. T is not met as evidenced view, clinical record review treview the facility staff failed orders for 1 of 25 Residents,		Residents #24's attending physical notified that the facility failed to that physician ordered Neurontiavailable for administration. A Incident and Accident form was completed for this incident. Identification of Deficient Practices/Corrective Action(s All other residents receiving m may have been potentially affer DON, QA nurse and Unit Man conduct a 100% audit of all res MAR's to identify resident at r Residents identified at risk will corrected at time of discovery attending physicians will be not each negative finding and a fact Incident & Accident Form will completed for each negative fit.	o ensure in was facility s c): edications cted. The agers will sidents risk. I be and their otified of cility I be	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
		495234	B. WNG		C 04/12/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH (XA) ID SUMMARY STATEMENT OF DEFICIENCIES			55	REET ADDRESS, CITY, STATE, ZIP CODE 80 DANIEL SMITH ROAD RGINIA BEACH, VA 23462 PROVIDER'S PLAN OF CORRE	
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 684	disorder. The most recent Man ARD (assessmedded the Resider cognitive status. The Resident #24's clin 04/10/18. It contains summary for the management of the management of the management of the management of the surveyor spotated that she do and does not remand administered, because it was not administered.	ADS (minimum data set) with ent reference date) of 02/01/18 at as 3 out of 15 in section C, his is an annual MDS. Inical record was reviewed on med a physician's order month of April which read in part a capsule give one cap po (by daily) for pain". The Resident's medication administration as reviewed and contained an an part "Neurontin 100mg cap po (by mouth) BID (twice his entry had been coded "N" on pm dose. It with RN (registered nurse) approximately 1515 regarding sident #24's eMAR. RN #1 the sent the medication was and that it might have been but available in the medication ked RN #1 what she would do if a not available and she stated, but to deliver, call the pharmacy	F 684	Systemic Change(s): The facility policy and procedure been reviewed and no revisions a warranted at this time. The nursin assessment process as evidenced 24 Hour Report and documentati medical record /physician orders the source document for the deve and monitoring of the provision of which includes following and administering medications per porders. The DON and/or Regions consultant will inservice all licentursing staff on the procedure for following and administering medication per physician order to include the procedure for obtaining medication pharmacy to ensure availability. Monitoring: The DON will be responsible for maintaining compliance. The DON unurse and/or Unit Managers will resident MAR's weekly to monic compliance. Any/all negative fir or errors will be corrected at time discovery and disciplinary action taken as needed. Aggregate find these audits will be reported to the Quality Assurance Committee of for review, analysis, and recommendations for change in policy, procedure, and/or practic Completion Date: May 25, 20.	by the on in the remains elopment of care, shysician all nurse used or dications e ions from the construction of care ions from the care ions from th

	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDI			(X3) DATE SURVEY COMPLETED C		
		495234	B, WING			0	4/12/2018	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			558	STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	200	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 684	Continued From pag	e 42	F	684			0000	
	team during a meetir approximately 1655.	20 0.						
	provided the surveyor error report, which remedication was not gestates medication was provided surveyor witraining form, which discussed: important overflow, calling phanot available and if no calling MD + notify Redocument". DON and	eximately 0945, the DON or with a copy of a medication and in part "5pm dose of given to Resident; nurse as not found". DON also of the a copy of an inservice read in part "1. Topics to be the of checking stat box rmacy when a medication is medication cannot be given the property of the company of the com						
	policy entitled "Medications", which Upon discovery that supply of a medication Resident, facility state action to obtain the uthe medication adminimmediately take the	sted and was provided with a cation Shortage/Unavailable read in part "Procedure 1. facility has an inadequate on to administer to a ff should immediately initiate medication from pharmacy. If tage is discovered at the time istration, facility staff should a action specified in Sections						
	medication shortage pharmacy hours: 2. pharmacy to determ the medication has licensed facility nurs reorder for the next next available delived dose in the Resident facility nurse should the Emergency Medithe dose. 2.3 If the	2.0, as applicable. 2. If a se is discovered during normal 1 Facility nurse should call ine the status of the order. If not been ordered, the se should place the order or scheduled delivery. 2.2 If the ery causes delay or a missed it's medication schedule, obtain the medication from dication Supply to administer medication is not available in dication Supply, facility staff						

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED		
		495234	B. WING			04/12/2018
	ROVIDER OR SUPPLIER HALL VIRGINIA BEAC	н		55	REET ADDRESS, CITY, STATE, ZIP CODE BO DANIEL SMITH ROAD RGINIA BEACH, VA 23462	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	6.77
F 684 F 695 SS=D	emergency delivery." The surveyor reques copy of the emergen medication Neurontin available in the emergen No further information Respiratory/Tracheo CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care at The facility must ensure and tracheal survey care and tracheal survey care, consistent with practice, the compressive plan, the reside and 483.65 of this sur This REQUIREMEN by: Based on observations.	ted and was provided with a cy medication supply. The n 100 mg was listed as being gency medication supply. In was provided prior to exit. stomy Care and Suctioning or tracheal suctioning. The including tracheal suctioning is provided such a professional standards of thensive person-centered ents' goals and preferences, abpart. T is not met as evidenced		684	F695 Corrective Action(s) Resident #50 and #67 have had their oxygen concentrators thoroughly cleaned and all filters have been cleaned. A facility Incident and Accident form was completed for this incident. Resident #136's attending physician was notified that the facility failed to administer oxygen at the ordered flow rate. Resident #136's oxygen concentral has been thoroughly cleaned, the Nebulizer mask and oxygen tubing has been replaced with a new one and were dated and stored in a clear plastic bag when not in use. A facility Incident &	s
	facility staff failed to equipment was mair (Resident #50, Resi to include cleaning of the physician order delivered and infection. The findings include 1. The facility staff #50's oxygen concern.	failed to ensure Resident			Accident form was completed for this incident.	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i) : NOTIBE 1000()		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 04/12/2018	
		495234	B. WNG				
NAME OF PE	ROVIDER OR SUPPLIER	<u> </u>		ST	REET ADDRESS, CITY, STATE, ZIP CODE		7.55
				55	80 DANIEL SMITH ROAD		
HERITAGE	HERITAGE HALL VIRGINIA BEACH			VII	RGINIA BEACH, VA 23462		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	02765	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETION DATE
E 605	C. Jin J. F.	- 44	-	695	Identification of Deficient Practice		
F 695	10 41 A 14		Г	090	& Corrective Action(s):	İ	
	3	18. Resident #50 was			All other resident receiving physician		
		ty 5/6/09 and readmitted			ordered oxygen may have potentially	1	
	_	ses that included but not			been affected. A 100% review of all	Ĩ	
		a following cerebral vascular			residents with physician ordered oxyge	n	
		nspecified side, adult failure to			was conducted to identify any/all		
	50	al deficiency, cognitive			residents at risk. Any negative findings	; d	
	18	cit, depressive disorder,			were corrected at time of discovery and new oxygen equipment was obtained a	nd	
	adrenocortical insuff				dated and stored correctly. As well as	all	
		xic multinodal goiter,			concentrators were inspected for		
		teral deep vein thrombosis,			cleanliness. A facility Incident		
	hypoxia, dementia,	and anemia.			&Accident form will be completed for	<u>*</u>	
	D:	lay minimum data set (MDS)			each negative finding.		
		assessment reference date			Systemic Change(s):		
		essed the resident with			The facility policy and procedure has		9
		problems, long-term memory			been reviewed and no changes are	ca	
		erately impaired cognitive skills			warranted at this time. All Nursing state	a l	
		aking. No indicators of			will be inserviced by the DON on the	10	
	delirium, behaviors				proper procedure for cleaning, changir and storing of Oxygen equipment to	18	
	demidin, benditors	or payarioois.			include cleaning concentrators and		
	During the initial tou	ır on 4/9/18, the surveyor			storage of nasal cannulas and nebulize	er e	
		#50 in bed with an oxygen			tubing and masks when not in use. As		
	parties and a contract of the	oned at the bedside. The			well as administering oxygen per		
	Section and a section of the section	or was set on 2 liters/nasal			physician ordered rate.		1
	TO SECURE A SECURITION OF THE PROPERTY OF THE	eyor noted an accumulation of			200 A 200		
	dust on the concent	# - professional control of the cont			Monitoring: The DON and/or Unit Manager is		
	Resident #50's Apri	il 2018 physician's order were			responsible for maintaining complian	ce.	
	reviewed. Orders r	ead "O2 at 2 LPM (liters per			The DON or Unit Manager will make	2	
1		e work of breathing and keep	1		weekly rounds to monitor for complia	ance.	
ł		turation) (greater than) 93%,			Any negative findings will be correct	ted at	
	change oxygen tubi	ing qweek (every week), and			time of discovery and disciplinary ac	tion	
ì		ubing and mask q week (every			will be taken as warranted. All negat	ive its:	
	week)."				findings will be reported to the Quali Assurance Committee for review,	ırı	
1		MARKATANNI ZADIAND BRI DINGRESIMPRA MI			Assurance Committee for review, analysis, and recommendations for		
		rved Resident #50 again on			change in facility policy, procedure,		
1		n. Resident #50 was in bed			and/or practice.		
		ncentrator set on 2 liters.			Completion Date: May 25, 2018		
1		rveyor observed a fair amount			Compression		
1	of dust and debris	on the concentrator, especially					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	90.1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY PLETED
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH				ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD INIA BEACH, VA 23462	_ _ 04	12/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	color was observed of tubing was dated 4/8 interviewed the unit in nurse #1 on 4/10/18. stated the dated tubing was changed. manager L.P.N. #1 oconcentrator togethe agreed with the survamount of accumula unit manager L.P.N. and stated she would LPN #1 stated she will ters when the tubin. The surveyor inform director of nursing of 4/10/18 at 4:55 p.m. policy on oxygen mastated the facility did specified cleaning of the surveyor review. Oxygen Administrated in part "Steps if face mask, tank, huit they are in good wo fastened. 10. Oxyg should be stored in when not in use." No further information exit conference on 4.2. The facility staff nebulizer facemask the oxygen concentration.	like substance greyish in on both filters. The oxygen 1/18. The surveyor manager licensed practical. The unit manager L.P.N. #1 ng indicated the date the 1. The surveyor and the unit observed the oxygen er. The unit manager L.P.N #1 eyor that there was a large ted dust on both filters. The 1/11 removed the air filters of take care of the issue. UM would expect staff to clean the ng was changed. The administrator and the filter and requested the facility aintenance. The administrator of the oxygen equipment. The oxygen equipment. The oxygen equipment of the Procedure 6. Check the midifying jar, etc., to be sure rking order and are securely en tubing, cannula/mask a clean, clear plastic bag	F	695			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495234 NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			IDENTIFICATION NUMBER: A. BUILDING				TE SURVEY MPLETED
		495234				C 04/12/2018	
			5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD HINIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	0.000	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 695	administration for The surveyor revierecord 4/9/18 throwas admitted to the that included but rurinary tract infect pulmonary diseas bursitis, morbid of osteoarthritis, gas apnea, depressive anemia, and vendamenia, and vendamenia tour on 4/9/was observed in the inightstand, the sumachine with a fafacemask was lying surveyor also observed in the facemask was lying surveyor also observed in the machine and the of the machine, he "powdery." The contentration that the intention of the surveyor informatical nurse #"concentrator was stated she thought tubing but when of LPN #1 the machine and the machine and the intention of the surveyor informatical nurse #"concentrator was stated she thought tubing but when of LPN #1 the machine."	in order for oxygen	F	695			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION	COMPLETED	
		495234	B. WING_		04/12/2018
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	SHOULD BE COMPLETION
F 695	ordered. The UM turned the oxygen Resident #136's A reviewed. Orders NC (nasal cannula oxygen tubing week The surveyor obset at 8:35 a.m. Resid oxygen on at 2 literoxygen concentrate debris on the front accumulation of the have a date when The surveyor inform of the above concentrate above concentrate above concentrate the manager washed them with back in the concentrated the oxygen changed 4/8/18. Would expect the and date the tubin surveyor did not concentrate the door. The surveyor information of the surveyor information of the door. The surveyor information of the surveyor info	LPN #1 stated "2" and promptly concentrator to 2 liter. pril 2018 physician's order were read "02 at 2 liters (liters) via a) continuous and change ekly." erved Resident #136 on 4/10/18 lent #136 was observed in bed, ers per nasal cannula. The tor was noted to have dust and and the air filters had an ust. The oxygen tubing did not the tubing was last changed. The oxygen tubing did not the tubing was last changed. The Unit manager LPN #1 erns on 4/10/18 at 8:36 a.m. LPN #1 removed the air filters, in water, and placed the filters intrator. The UM LPN #1 also tubing should be dated when The tubing should be dated when The tubing should have been The UM LPN #1 stated she nursing staff to clean the filters ing weekly. In addition, the observe a "No Smoking" sign on the end nurse of the above concerns 38 a.m. Interest the administrator and the gof the above concern on .m. and requested the facility	F	695	
	on 4/10/18 at 10:3 The surveyor info director of nursing 4/10/18 at 4:55 p policy on oxygen stated the facility	38 a.m. Immed the administrator and the g of the above concern on			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 252 5	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495234	B. WNG	B WING		С	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			55	REET ADDRESS, CITY, STATE, ZIP CODE 80 DANIEL SMITH ROAD RGINIA BEACH, VA 23462	<u> </u>	12/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 695	"Oxygen Administratic read in part "Steps in facemask, tank, hum they are in good worf fastened. 10. Oxyge should be stored in a when not in use." No further information exit conference on 4.3. The facility staff facequipment for Resident #67 was real/10/18 with the follow limited to anemia, he pressure, Alzheimer' Parkinson's disease, depression, manic do Obstructive Pulmona On the MDS (Minimu (Assessment Reference the resident with a B Mental Status) score of 15. Resident #67 limited assistance of and extensive assist personal hygiene. Ras being totally dependent.	ed the facility policy titled for on 4/11/18. The policy of the Procedure 6. Check the idifying jar, etc., to be sure king order and are securely in tubing, cannula/mask oclean, clear plastic bag on was provided prior to the 4/12/18. Sailed to maintain respiratory ent #67. admitted to the facility on wing diagnoses of, but not eart failure, high blood is disease, dementia, anxiety disorder, epression and Chronic	F	695			
	resident's room and O2 (oxygen) at 2 l/m cannula. The oxyger	m, the surveyor went into the noted that Resident #67 had in (liters per minute) by nasal tubing was dated with a O2 concentrator's filter was					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING		COMPLETED	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STF 558	REET ADDRESS, CITY, STATE, ZIP CODE TO DANIEL SMITH ROAD RGINIA BEACH, VA 23462	04/12/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 755 SS=D	that was visible to the was notified of the fill particles of debris visible would have this surveyor asked LPN staff to clean the oxy LPN #1 stated she will filter when the oxyge weekly basis. The surveyor notifies the above document 3:12 pm in the confermation of the pharmacy Srvcs/Pro CFR(s): 483.45(a)(b) §483.45 Pharmacy The facility must prodrugs and biological them under an agree §483.70(g). The facility must prodrugs and biological them under an agree §483.70(g). The facility must prodrugs and biological to admin permits, but only under a licensed nurse. §483.45(a) Procedure pharmaceutical ser that assure the accordispensing, and additional biologicals to mee §483.45(b) Service §	st and particles of debris on it e surveyor's eye. LPN #1 ter being dirty with dust and sible to the eye. She stated taken care of right now. The #! When she would expect rgen concentrator's filter. rould expect staff to clean the en tubing was changed on a d the administrative team of ted findings on 4/12/18 at erence room. on was provided to the e exit conference on 4/12/18. becedures/Pharmacist/Records o)(1)-(3) Services ovide routine and emergency Is to its residents, or obtain	F 755	F755 Corrective Action(s): Resident 41's attending physician has been notified that the facility failed to ensure that the physician ordered Methocarbamol medication was avai from pharmacy for administration to Resident #41. A facility Incident and Accident form has been completed for this incident. Resident 65's attending physician has been notified that the facility failed to ensure that the physician ordered McContin medication was available from pharmacy for administration to Resimple #65. A facility Incident and Accident form has been completed for this incident.	lable lor us to S om dent nt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING				(X3) DATE SURVEY COMPLETED	
				**************************************			С	
		495234	B. WING	p. A		04	V12/2018	
NAME OF P	ROVIDER OR SUPPLIER	10 It lay 2000-200 to 10 100	-0.	STR	EET ADDRESS, CITY, STATE, ZIP COD	E		
(IEDITA 01		· Cal		558	O DANIEL SMITH ROAD			
HERITAGE	E HALL VIRGINIA BEAC	.п		VIR	GINIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	200	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 755	§483.45(b)(1) Provide aspects of the provision the facility. §483.45(b)(2) Estably receipt and disposition sufficient detail to erreconciliation; and second and partial second and par	des consultation on all sion of pharmacy services in lishes a system of records of on of all controlled drugs in hable an accurate mines that drug records are in ecount of all controlled drugs eriodically reconciled. It is not met as evidenced eview, clinical record review, view and in the course of a sion the facility staff failed to were available for of 25 Residents, #41 and ed:	\$ 3/49/55/04	755		entially been fall resident's en conducted l' or Unit ents at risk. sk due the able from the l at time of ng physicians Incident and empleted for Procedure has nges are rising staff have icy and administration at are eat the facility for ice will include l take should a ed timely from or maintaining DON or Unit ekly audits of k to confirm the drugs. All corrected at the is of the reviews		
	an ARD (assessme	DS (minimum data set) with ent reference date) of 02/16/18 tas 15 of 15 in section C, his is a quarterly MDS.			Committee for review, an recommendations for cha policy, procedure, and/or Completion Date: May 2	alysis, and nge in facility practice.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1- 1499-000 140	TIPLE CONSTRUCTION		TE SURVEY MPLETED C
		495234	B, WING			04/12/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH				STREET ADDRESS, CITY, STATE, ZIP C 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 755	04/11/18. It contains summary for the morpart "Methocarbame (1,000 mg total) poday) DX (diagnosis Resident's eMAR (or was reviewed and or in part "Methocarbatabs (1,000 mg totatimes a day) DX (di This entry was code pm. The comments note, which read in (Scheduled: 1:00F 500 mg tablet) Met tascheduled for PM.mediciation in the surveyor spok assurance) on 04/2 Surveyor asked Oxide stood for, and she medication was not the surveyor required policy entitled "Me Medications", which upon discovery the supply of a medical Resident, facility saction to obtain the	cal record was reviewed on ed a physician's order onth of March, which read in ol 500mg tablet give two tabs (by mouth) QID (four times a): muscle spasms". The electronic medication record) contained an entry, which read amol 500mg tablet give two ol) po (by mouth) QID (four tagnosis): muscle spasms". ed with "N" for 03/29/18 at 1 is section of the eMAR had a part "3:02 PM, 3/39/18 eMm 3/28/18; Methocarbamol hocarbamol 500 mg give two 03/29/2018 1:00 route //03/29/2018 3:02 PM". e with the QA nurse (quality 10/18 at approximately 1530. A nurse what "N" on the eMAR stated "N" means the stadministered". ested and was provided with a dication Shortage/Unavailable th read in part "Procedure 1. at facility has an inadequate ation to administer to a taff should immediately initiate e medication from pharmacy. If	F	755		
	of medication adm immediately take t 2 or 3 of the policy medication shorta	ortage is discovered at the time inistration, facility staff should the action specified in Sections 7.0, as applicable. 2. If a ge is discovered during normal 2.1 Facility nurse should call				

MANE OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPICEWON MUST BE PRECEDED BY PULL PREFIX (ACH CORRECTION MUST BE PRECEDED BY YOUL). PREFIX (ACH CORRECTION SOULD BE PRECEDED BY YOU.) PREFIX (ACH CORRECTION SOULD BE PREFIXED. F 755			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 00		STRUCTION	7.00,000	SURVEY PLETED
REALL VIRGINIA BEACH SIJAMARY STATEMENT OF DEFICENCIES CANCELL PERCENCY MAY SEPRECEDED BY FILL REGULATORY OR LISC IDENTIFYING INFORMATION PREFIX TAG PROVIDER'S PLAN OF CORRECTION CANCELL PROVIDER'S PLAN OF CANCELL PROVIDE			495234	B. WING	922		04	/12/2018
F755 Continued From page 52 pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2. If the next available delivery causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 if the medication is not available in the Emergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery'. The surveyor requested and was provided with a copy of the emergency medication supply. The medication Methocarbamol was not listed as being available. The surveyor spoke with the administrator on 04/11/18 at approximately 1530 regarding Resident #41. The concern of the medication not being available for administration was brought to her attention at this time. Administrator stated that she might possibly have some information regarding this. The concern of the medication not being available for administration was discussed with the administration was	MAI SI	Held St. DESIGNATION OF THE CONTRACTOR OF THE C			5580	DANIEL SMITH ROAD		
pharmacy to determine the status of the order. If the medication has not been ordered, the licensed facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the Resident's medication schedule, facility nurse should obtain the medication from the Ernergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Ernergency Medication Supply, facility staff should notify pharmacy and arrange for an emergency delivery. The surveyor requested and was provided with a copy of the emergency medication supply. The medication Methocarbamol was not listed as being available. The surveyor spoke with the administrator on 04/11/18 at approximately 1530 regarding Resident #41. The concern of the medication not being available for administration was brought to her attention at this time. Administrator stated that she might possibly have some information regarding this. The concern of the medication not being available for administrative team during a meeting on 04/11/18 at approximately 1715. No further information was provided prior to exit. This is a complaint deficiency. 2. The facility failed to ensure that a physician ordered medication was available for	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
Resident #65 was readmitted to the facility on	F 755	pharmacy to determithe medication has ricensed facility nursing reorder for the next so next available delived dose in the Resident facility nurse should the Emergency Medithe dose. 2.3 If the niche Emergency Medishould notify pharmatemergency delivery. The surveyor requescopy of the emerger medication Methocabeing available. The surveyor spoke 04/11/18 at approximate for a strention at this she might possibly being available for a her attention at this she might possibly being available for administration wadministrative team at approximately 17. No further information or facility failed ordered medication administration to Resident available for a for administration to Resident medication administration to Resident medication administration to Resident failed ordered failed ordere	ne the status of the order. If not been ordered, the e should place the order or scheduled delivery. 2.2 If the ry causes delay or a missed is medication schedule, obtain the medication from ication Supply to administer nedication is not available in ication Supply, facility staff acy and arrange for an ication supply. The resemble was not listed as with the administrator on mately 1530 regarding concern of the medication not administration was brought to time. Administrator stated that have some information medication not being available as discussed with the during a meeting on 04/11/18 15. on was provided prior to exit. deficiency. It to ensure that a physician was available for esident #65.	F	755			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED C	
		495234	B. WING		<u> </u>	0	4/12/2018	
Ethiniteou sotie as	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			5580 D	FADDRESS, CITY, STATE, ZIP CODE ANIEL SMITH ROAD NIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	3000	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 755	12/22/17 with the folimited to diabetes, Depression and Ps On the quarterly M an ARD (Assessmand 15 out of a possible was also coded as of 1 staff member of the surveyor concorded for 2/7/18 at Resident MS (MS (Pharmacy) was consurance would never was given a oxycorded on the surveyor reviewed february 2018 and "MS Contin 30 mg (by mouth) Q (ever surveyor also reviewed a month of February 10:00 pm for the rewas a "N" with the nurses' in at 6 am, in the bothere was a "N" with the surveyor reviewed and the surveyor reviewed at 6 am, in the bothere was a "N" with the surveyor reviewed and the surveyor reviewed at 6 am, in the bothere was a "N" with the surveyor reviewed and the surveyor reviewed and the surveyor reviewed and the surveyor reviewed and the surveyor also reviewed and the surveyor also reviewed and the surveyor reviewed and the surveyor reviewed and the surveyor also reviewed and the surveyor also reviewed and the surveyor reviewed and the surveyor also reviewed and the surveyor also reviewed and the surveyor also reviewed and the surveyor reviewed and the s	bollowing diagnoses of, but not Multiple Sclerosis, Manic sychotic Disorder. DS (Minimum Data Set) with ent Reference Date) of ent was coded as having a ew for Mental Status) score of e score of 15. Resident #65 requiring extensive assistance for dressing and personal totally dependent on 1 staff	F	755				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED		
		495234	B. WING	40.00	04/12/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD GINIA BEACH, VA 23462	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 755	4/11/18 at approxistated, "I will have and find out why the available." The set the "N" stood for in resident's MAR condumented date MS Contin. The Extremedication was the medication was the pharmacy and pharmacy on 2/5/DON stated that she has the pharmacy on 2/5/DON stated that the person the surveyor. The phone number of pharmacy. At 2 pm, the surveyor at the phone number of pharmacy. At 2 pm, the surveyor at the phone number of pharmacy. At 2 pm, the surveyor at the phone number of pharmacy.	mately 10:45 am. The DON to look into this a little deeper his medication was not unveyor asked the DON what in the documentation on the incerning the above and times for the medication of DON stated, "The N means that is not given." If to the surveyor at 1:30 pm and id looked over the manifest from if the facility had called the 18 and again on 2/6/18. The she had spoken to at pharmacy facility uses) and here would be glad to speak to a DON gave the surveyor the this contact person at the eyor called Pharmacy contact #1 ber supplied by the DON. Pharmacy contact #1 that ty had called the pharmacy on ed to the pharmacy that they hefill on the resident's MS Contin. Chnician had contacted the resident and it had been denied The facility called again on to a pharmacy technician	F 755		
	medication. Inste going ahead and at the pharmacy on this medicatio delivery date to 2 later in the day o was not changed	eed for the refill on the resident's ead of the pharmacy technician pushing thru the channels here and asking for an emergency fill in which would had changed the 1/6/18 this was not done until in 2/6/18 and the delivery date and it was delivered to the 1 on 2/7/18. In my opinion, the			

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED C
495234	B. WING	8 NOS 18 18 18 18 18 18 18 18 18 18 18 18 18	04/12/2018
	558	0 DANIEL SMITH ROAD	
DEFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
pped within the pharmacy on this. at 3:12 pm, the surveyor notified the re team of the above documented of the above documented of the team of the above documented of the exit conference on 4/12/18. an Review, Report Irregular, Act On 6.45(c)(1)(2)(4)(5) Crug Regimen Review. at The drug regimen of each resident fiewed at least once a month by a farmacist. This review must include a review ent's medical chart. The pharmacist must report any is to the attending physician and the dical director and director of nursing, eports must be acted upon. The pharmacist include, but are not limited to, any eets the criteria set forth in paragraph ection for an unnecessary drug, gularities noted by the pharmacist review must be documented on a mitten report that is sent to the hysician and the facility's medical director of nursing and lists, at a the resident's name, the relevant drug, egularity the pharmacist identified. The endical record that the identified on the endical record that the identified.	F 756	F756 Corrective Action(s): Resident #34 has had their January pharmacy recommendations review signed by the DON. A facility Incident Accident form has been complifor this incident. Identification of Deficient Practic Corrective Action(s): All other residents may have been potentially affected. The DON has reviewed all consultant pharmacy recommendations for 2018 to iden residents in need of pharmacy recommendations, follow up, and by the DON. Systemic Change(s): The facility Policy and Procedure been reviewed and no changes are warranted at this time. The DON inserviced on the revised Federal Regulations for drug regime reviewed DON will review and sign all pharecommendations monthly as requested that any/all pharmacy recommendations have been addrand proper notification to attending physicians has been completed.	dent leted ces & s stify review has has been ew. The urmacy uired to ressed
	IDENTIFICATION NUMBER:	PLIER ### A 95234 PLIER ### A 95234 ### BEACH ### A 95234 ### BEACH ### BEACH ### BEACH ### A 95234 ### BEACH ## BEACH ### BEACH ### BEACH ### BEACH ### BEACH ### BEACH ### BEACH ### BEACH ###	PLIER A STREET ADDRESS, CITY, STATE, 2IP CODE SSO DANIEL SMITH ROAD WIRGINIA BEACH, VA 23462 IP PROVIDERS PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCE TO THE APPR DEFICIENCY) F 755 Trom page 55 pped within the pharmacy on this. at 3:12 pm, the surveyor notified the or to the exit conference on 4/12/18. en Review, Report Irregular, Act On 1.45(c)(1)(2)(4)(5) The drug regimen of each resident lewed at least once a month by a armacist. 2) This review must include a review ent's medical chart. 4) The pharmacist must report any s to the attending physician and the dical director of and director of nursing, eports must be accumented on a vitten report that is sent to the hysician and the facility's medical director of nursing and lists, at a he resident's name, the relevant drug, gularities noted by the pharmacist review must in other dical director of nursing and lists, at a he resident's name, the relevant drug, gularities noted by the pharmacist identified. ending physician must document in the medical record that the identified has been reviewed and what, if any, been taken to address it. If there is to

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495234	B. WNG		04/12/2018	8	
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL VIRGINIA BEACH			STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLI	ETION	
F 756	physician should do the resident's media §483.45(c)(5) The maintain policies an drug regimen revie limited to, time fran the process and str when he or she ide requires urgent act This REQUIREME by: Based on staff inte review, the facility director of nursing review for one of 2 sample (Resident: The findings include Resident #34 was 12/4/14 with the fol limited to Peripher hyperlipidemia (hig Alzheimer's disease On the quarterly N an ARD (Assessm 2/23/18, the reside and long term met moderately impair Resident #34 was extensive assistar dressing and pers dependent on 1 st The surveyor cone #34's clinical reco	facility must develop and facility must develop an irregularity that facility facility must develop an irregularity that facility facility must develop an irregularity that facility facility must develop and clinical record staff failed to ensure the signed the drug regimen 5 Residents in the survey #34).	F 754	Monitoring: The DON is responsible for ma compliance. The DON will perform monthly audits of the pharmacy recommendations are being revisigned by the DON and the atter physician. Any/all negative find be corrected at time of discover Management Tracking/Trendin will be completed for each incidentified. Detail findings of the will be reported to the Quality. Committee for review, analysis recommendations for change in policy, procedure, and/or pract Completion Date: May 25, 20	form t the iewed and ending dings will ry. A Risk g Report dent is review Assurance s, and n facility ice.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1		IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495234	B. WNG		C 04/12/2018
1750 Avr. 2761 (Aug. 277 - 277 - 277	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	
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F 756	January 1, 2018 thr from the pharmacist. signed and acknowle and was dated "2 1 1 that the physician had check mark in the bore-evaluated this ther implement any chang below. Rationale: We recert (recertification) surveyor that on this was no signature on nursing. At approximately 3 per Consultation Report in notified her of the misher. The director of relooking at this with that 5:15 pm, the surveyor prior to the Drug Regimen is Free CFR(s): 483.45(d)(1) §483.45(d) Unnecess Each resident's drug unnecessary drugs, drug when used-	This recommendation was diged by the medical director 8". The surveyor also noted of marked a response with a context that stated, "I have apy and DO NOT wish to see due to the reasons fill f/u (follow up) @ (at) next ." It was noted by the Consultation Report, there this by the director of this by the director of the director of nursing and asing signature on this by the surveyor. By or notified the surveyor. By or notified the sexit conference on 4/12/18. Be from Unnecessary Drugs -(6) sary Drugs-General. The regimen must be free from An unnecessary drug is any dessive dose (including by); or	F 75		eived the s without first ical dent &

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	80 Hadring 2000		ONSTRUCTION		TE SURVEY MPLETED
		495234	B. WING			c	C 04/12/2018
NAME OF PE	ROVIDER OR SUPPLIER			STA	REET ADDRESS, CITY, STATE, ZIP CODE		
				558	0 DANIEL SMITH ROAD		
HERITAGE	E HALL VIRGINIA BEAC	ЭН			RGINIA BEACH, VA 23462		
55	3070,000 May 1000 May		1		e dans a capacitamente de la processión de la desente de la desente de la defenda ión de la defenda		100 - 10
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F 757	Continued From pag	ge 58	F	757	Resident #184's attending physician	was	
	8483 45(d)(3) Witho	out adequate monitoring; or			notified that resident #184 received the		
	3-100.10(0)(0) 111.110	.a. 20042210			pain medication Tramadol HCL 50mg	3	
	§483.45(d)(4) Withouse; or	out adequate indications for its			without first attempting non- pharmacological interventions. A fac- Incident & Accident form was compl for this incident.	lity eted	ж.
	§483.45(d)(5) In the	presence of adverse			for uns meldone.		İ
		h indicate the dose should be			Identification of Deficient Practice	(s)	
	reduced or discontin	nued; or		8	and Corrective Action(s):	2	1
					All other residents receiving PRN pa		İ
		combinations of the reasons			medications may have been potential		
		s (d)(1) through (5) of this			affected. The DON, QA Nurse and/o Unit Managers will review the Pain	<u>r</u>	
	section.				medication orders of all residents to		
	N 20 20 20 20 20 20 20 20 20 20 20 20 20	NT is not met as evidenced			ensure that non-pharmacological		
	by:			,	interventions are attempted prior to		ľ
		rview and clinical record			administering PRN Pain medications	L.	
Ĭ		staff failed to provide		1	Any/all negative findings will be		
		al interventions prior to			addressed with nursing staff for corraction. A Facility Incident & Accide		
		medications for 2 of 25			form will be completed for each neg		
	#184).	vey sample (Resident #67 and			finding.		
ŀ	# 10 - y.				-		
	The findings include	ed:			Systemic Change(s): The facility Policy and Procedure ha	ıs	
	1. The facility staff f	failed to provide			been reviewed. No revisions are warranted at this time. All nursing s	taff	ļ
1		al interventions prior to			will be inserviced by the DON and/o		
		medications to Resident #67.	700 mm m m m m m m m m m m m m m m m m m		regional nurse consultant and issued		
					copy of the facility policy and proce		ŀ
	Resident #67 was r	readmitted to the facility on		2	for proper administration and monit		
	1/10/18 with the foll	lowing diagnoses of, but not			of all medications. This includes		
	E S	neart failure, high blood		9	attempting non-pharmacological	of	
	II - S	er's disease, dementia,			interventions prior to administration PRN pain medication.	UI	
	Parkinson's disease		la la la la la la la la la la la la la l	98	T KIN pain incoreation.		
		depression and Chronic					
		nary Disease. On the MDS					
		t) with an ARD (Assessment					
	1.00	1/22/18 coded the resident	1				
		Interview for Mental Status)	1				
		possible score of 15.					5 1
I .	Resident #6/ was a	also coded as requiring limited					3 8

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495234	B. WING_				04/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BE	АСН		558	REET ADDRESS, CITY, STATE, ZIP CODE O DANIEL SMITH ROAD RGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 757	assistance of 1 streams as a stream and hygiene. The surveyor perf #67's clinical recorreview, it was not MAR (Medication month of April 20' following pm (as a "Norco 5-325 Tab hours as needed administrated to the dates and times: at 9:15 am, 2:56 am and 8:05 pm, surveyor reviewed the end of the MA non-pharmacologistic than a surveyor reviewed and under the profession of the matter and under the professio	aff member for dressing and noce of 1 staff member for Resident #67 was as being on 1 staff member for bathing. Formed a review of Resident and on 4/10/18. During this led by the surveyor that on the Administration Record) for the 18, the resident received the needed) pain medication: let Take one tablet every 4 for pain." This medication was the resident on the following 4/2 at 9:48 am and 4:02 pm, 4/3 pm, 4/6 at 7:53 am, 4/7 at 5:37 and 4/8 at 5:39 am. The dithe Administration Record at AR and the only gical intervention documented for istration times of the pm pain Assessed for pain". iewed the resident's care plan oblem of "Alteration of comfort r/t the interventions read in part: worsening pain or pain not rrent therapy, notify MD (medical use in strength or change in med. Invironment and assist with omfort -pharmacologic pain relief as repositioning, back rubs.	F	757	Monitoring: The DON is responsible for maintacompliance. The DON, Unit Mana and/or designee will complete wee MAR audits coinciding with the Calendar to monitor compliance. In negative findings will be corrected immediately and appropriate discinaction will be taken as necessary. Aggregate findings of these audits provided to the Quality Assurance Committee for review, analysis, a recommendations for change in fapolicy, procedure, and/or practice Completion Date: May 25, 2018	ger ekly eare plan All i plinary s will be e nd acility	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		SURVEY PLETED
		495234	B. WNG			2007 10	C /12/2018
E. No. 3-11 1 -11 , 47-20, 111-2	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	1		5580	ET ADDRESS, CITY, STATE, ZIP CODE DANIEL SMITH ROAD SINIA BEACH, VA 23462		112.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- L	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 757	The DON stated that non-pharmacological her staff. The survey was the only non-pharmacological that she would expect them administrating a resident. The DON scan use." The survey were any other intervuse before administrationing from but assident and she state coming from but assident." The surveyor notified the above document 4:58 pm in the confect the above document 4:58 pm in the confect the surveyor again the team on 4/11/18 at 5 documented findings no non-pharmacological assess for pain use of a pm pain medical No further information surveyor prior to the 2. The facility staff fanon-pharmacological administering pain in Resident #184 was 4/6/18 with the following blood pressure and the surveyor prior to the surveyor prior to the 2. The facility staff fanon-pharmacological administering pain in Resident #184 was 4/6/18 with the following blood pressure and provided to C-Diff, many blo	ation of a prn pain medicine. assess for pain was a Intervention to be used by or asked the DON if that armacological intervention at her nurses to use prior to a prn pain medication to a stated, "It is one that the staff or asked the DON if there ventions that the staff could ating prn pain medicine to a ted, "Yes I see where you are essing for pain is one of If the administrative team of ted findings on 4/10/18 at arence room. Inotified the administrative is on Resident #67 regarding gical interventions except for ted prior to the administration ation. In was provided to the a exit conference on 4/12/18.	F	757			

STATEMENT OF C	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9 45	IPLE CONSTRUCTION		DATE SURVEY COMPLETED C
		495234	B. WNG		·	04/12/2018
	OVIDER OR SUPPLIER HALL VIRGINIA BEAC	н		STREET ADDRESS, CITY, STA 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	survey in the nursing admission nursing at was documented the oriented. It was also #184 requires extensionember for transfers and bathing. During the clinical resurveyor on 4/11 and the resident had a p following pain medic (milligram) tablet - ta hours as needed DX. The surveyor review Administration Record that Resident #184 on the following date and 4/9 at 1:35 am. intervention that wa Administration Record Tramadol was giver pain. The surveyor notified the above documents: 3:15 pm. No further informatis surveyor prior to the	impleted at the time of this facility. According to the assessment dated for 4/6/18, it is the resident is alert and documented that Resident sive assistance of 1 staff is, walking, personal hygiene accord review performed by the d 4/12/18. It was noted that hysician order for the lation: "Tramadol HCL 50 mg lake 1 tab by mouth every 6		757		
SS=D	S483.45(c)(3) A psy affects brain activiti					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED C
- 12		455234			04/12/2018
NAME OF P	ROVIDER OR SUPPLIER		(REET ADDRESS, CITY, STATE, ZIP CODE	
UEDITACE	HALL VIRGINIA BE	A CH	558	0 DANIEL SMITH ROAD	
HERITAGE	E HALL VIRGINIA DE	ACH	VIR	RGINIA BEACH, VA 23462	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID I	PROVIDER'S PLAN OF CORRECTION	(X.5)
PREFIX		ENCY MUST BE PRECEDED BY FULL.	PREFIX	(EACH CORRECTIVE ACTION SHOULD B	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRI	ATE DATE
	<u> </u>			DEFICIENCY)	
		8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8			
F 758	Continued From p	age 62	F 758	F 758	
		havior. These drugs include,	19903 0249000000	Corrective Action(s):	
		to, drugs in the following		Resident #70's attending physician w	as N
	Townstream - content Silvertrockers salts to	to, drugs in the lollowing		notified that resident #70 received PR	
	categories:			Xanax without an appropriate clinical	
	(i) Anti-psychotic;	r.		indication to support its use and no no pharmacological interventions were to	nied
	(ii) Anti-depressar			prior to medication administration. A	.rcu
	(iii) Anti-anxiety; a	ind		facility Incident & Accident form was	
	(iv) Hypnotic		}	completed for this incident.	
				completed for this incident	
	Based on a comp	rehensive assessment of a		Identification of Deficient Practice	6)
	resident, the facili	ty must ensure that		and Corrective Action(s):	
	The transfer of the control of the C	CONTRACTOR CONTRACTOR		All other residents receiving antipsyc	hotic
	\$483.45(e)(1) Res	sidents who have not used		medications may have been potential	lv
		s are not given these drugs	1	affected. The DON, ADON, and/or	
		ation is necessary to treat a		Pharmacy consultant will review the	
		as diagnosed and documented		medication orders of all residents	
	in the clinical reco			receiving psychotropic/antipsychotic	
	In the dirical red	Ju,		medications to ensure that no unnece	ssary
	0400 45(-\/0\ D-	-idt- who use povobetropic		medications have been ordered and t	hat
		sidents who use psychotropic		all antipsychotic medications have a	ı
		dual dose reductions, and		appropriate medical diagnosis and/or	
		entions, unless clinically		clinical indication for their use. Any	all
	2200 Telescorrescondo 51440	n an effort to discontinue these		negative findings will be communicated	ited
	drugs;		1	to the attending physicians for corre	live
	NA SERVINENE METHODOS DE POZONE OSTORIO	Marie and a s		action. A Facility Incident & Accide	nt
		sidents do not receive		form will be completed for each neg	auve
		gs pursuant to a PRN order		finding.	
		cation is necessary to treat a		Sentemia Changa(a):	
	diagnosed specif	ic condition that is documented		Systemic Change(s): The facility Policy and Procedure ha	ne l
	in the clinical rec	ord; and		been reviewed. No revisions are	10
	www.com.com.com.com.com.com.com.com.com.com			warranted at this time. All nursing s	staff
1	§483.45(e)(4) PF	RN orders for psychotropic drugs		will be inserviced by the DON and/o	or
	are limited to 14	days. Except as provided in		regional nurse consultant and issued	a
	8483,45(e)(5) if	the attending physician or	*	copy of the facility policy and proce	dure
		itioner believes that it is		for proper administration and monit	oring
		ne PRN order to be extended		of psychotropic medication to inclu	de
F		he or she should document their	Ÿ	antipsychotic medications. This inc	ludes
	peyond 14 days,	esident's medical record and	1 1 1 1 1 1	having an appropriate medical diag	nosis
1				or clinical indication for its use and	the
1	indicate the dura	tion for the PRN order.		use of non-pharmacological interve	
	50			prior to using medication.	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVI COMPLETED	
		495234	B. WNG		С	
NAME OF P	ROVIDER OR SUPPLIER	433234	I Enternment K	TREET ADDRESS, CITY, STATE, ZIP CODE	04/12/20)18
			70% (1)%	580 DANIEL SMITH ROAD		
HERITAGE	HALL VIRGINIA BEAC	н		/IRGINIA BEACH, VA 23462		
WA IB	CI NAMA DV CT	ATEMENT OF DEFICIENCIES			CTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE COM	(X5) IPLETION DATE
F 758	drugs are limited to 1 renewed unless the apprescribing practition the appropriateness. This REQUIREMENT by: Based on staff intervereiew, the facility staresidents was free of psychotropic medical. The findings included. The facility staff failed was free of an unned facility staff failed to non-pharmacologic in of Xanax on five (5). The clinical record of 4/9/18 through 4/12/admitted to the facility included but not limit bradycardia, hypokal enterocolitis due to 0 disorder, chronic obshyperlipidemia, pulm Takotsubo syndrome esophagus, left ventre.	rders for anti-psychotic 4 days and cannot be attending physician or er evaluates the resident for of that medication. It is not met as evidenced riew and clinical record aff failed to ensure 1 of 25 if an unnecessary tion (Resident #70). It: It: It to ensure Resident #70 ressary medication. The offer/provide interventions prior to the use different occasions. If Resident #70 was reviewed Its. Resident #70 was ry 2/19/18 with diagnoses that led to atrial fibrillation, lemia, long QT syndrome, clostridium difficle, anxiety structive pulmonary disease, lemary hypertension,	F 758		ger thly re plan all blinary will be	
	resident with a brief a 15. Both anxiety a Section I Active Diag	•				
	II.	th 2018 physician order sheet r Xanax 0.25 mg (milligrams)				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	W M	PLE CONSTRUCTION G	(X3) DATE SURVE COMPLETED
		495234	B. WING		04/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н		STREET ADDRESS, CITY, STATE, ZIP CODI 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	=
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 758		e 64 ery) 12 hours pm (as needed)	F 7	58	
	medication administre MAR notes. Resid Xanax 0.25 mg on 3 resident request. Xa administered 3/21/1 documented for the Xanax. Xanax 0.25 at 12:10 a.m. The 3 resident request." Fadministered Xanax p.m. No reason for medication was ider Xanax 0.25 mg on 3	8 at 5:50 p.m. No reason administration of the prn mg was administered 3/23/18 //23/18 notes stated "per			
	for March 2018. The of non-pharmacolog	yed the Departmental Notes e notes did not have evidence lic interventions prior to the reason for the administration request."			
	1:09 p.m.) did not h administration of the	s dated 3/10/18 (6:13 a.m. and ave any reasons for the axanax or any use prior to the administration			
	not reference any n	dated 3/21/18 (1:49 a.m.) did on-pharmacologic intervention canax. The note read in part ood."			
	or the 3/24/18 note	ote dated 3/23/18 at 6:51 a.m. of 12:55 a.m. did not pharmacologic intervention			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		E SURVEY IPLETED
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	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
- NEW 1885 NO40	3/24/18 after 12:55 a at 12:22 a.m. did not non-pharmacologic in administration of Xar. The surveyor informed director of nursing of non-pharmacologic in of Xanax or the lack of Xanax in the end of at 5:15 p.m. The DC review the information with conference on 4.	artmental note written .m. The note written 3/25/18 reference any type of ntervention or reason for the nax. ed the administrator and the the lack of nterventions prior to the use of documentation for the use of the day meeting on 4/11/18 N stated she wanted to n provided. n was provided prior to the 1/2/18. dentifiable Information	F 7	42 F842 Corrective Action(s):		
	(i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a cagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance can be seen to the extent to do so.	elease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted ds and practices, the facility cal records on each resident		Resident #45's Pharmacy Consequence of Resident #57's Pharmacy Consequence of Resident form has been complethis incident. Resident #57's Pharmacy Consequence of Resident #57's Pharmacy Consequence of Resident form has been complethis incident. Resident #234's attending physical been notified that the facility set of accurately document the address of Resident 234's morning meter of Resident form has been complethis incident.	nt 45's dent & eted for sultation by the dent 95's dent & eted for sician has taff failed ministration dications t &	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	ETÉD
		495234	B. WING		500	2/2018
	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 10 DANIEL SMITH ROAD		
HERITAGE	E HALL VIRGINIA BE	EACH	VIF	RGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	(iii) Readily access (iv) Systematicall §483.70(i)(2) The all information coregardless of the records, except v (i) To the individure presentative with the information operations, as possible with the reglect, or dome activities, judicial law enforcement purposes, researmedical examines a serious threat by and in complition of the purpose of the information of the period of (ii) The period of (iii) Five years from there is no require (iii) For a minor, legal age under §483.70(i)(5) The (i) Sufficient information of the i	ssible; and y organized a facility must keep confidential intained in the resident's records, form or storage method of the when release is- ial, or their resident here permitted by applicable law; .aw; at, payment, or health care ermitted by and in compliance is- 506; alth activities, reporting of abuse, estic violence, health oversight and administrative proceedings, estic violence, not ocoroners, funeral directors, and to avert to health or safety as permitted ance with 45 CFR 164.512. The facility must safeguard medical on against loss, destruction, or e. The dical records must be retained in time required by State law; or om the date of discharge when irement in State law; or 3 years after a resident reaches	F 842	Resident #48's attending physicial been notified that the facility staft to accurately document that the pordered Clip Alarm was in place ordered. A facility Incident & Acform has been completed for this Resident #87's attending physicial been notified that the facility state to accurately document that the pordered treatments to the right in were completed as ordered for 2 facility Incident & Accident for been completed for this incident. Identification of Deficient Prace Corrective Action(s): All other residents may have posteen affected. A 100% review resident Medical Records will be conducted by the DON, QA Nudesignee to identify residents at negative findings will be clarific correct as applicable at time of A facility Incident & Accident be completed for each negative. Systemic Change(s): The facility policy and proceduse mursing staff, Social Services Activity Director and dietary will be inserviced by the Region Consultant or DON on the clip documentation standards per policy and procedure. This trainclude the standards for main accurate medical records and documentation to include Phy Orders, MAR's, TAR's and documentation to include Phy Orders, MAR's, TAR's and documentational standards and professional	as acident as acident an has acident and a has acident and a has acident and a has acident and a has acident and a has acident and a has acident and a has acident and a has acident and a has acident an acident and a has acident and a has acident and a has acident and a has acident and a has acident and a has acident and acident an acident and acident and acident an acident and acident and acident and acident and acident and acident ac	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE COMP	LETED
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	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	Н		558	REET ADDRESS, CITY, STATE, ZIP CODE O DANIEL SMITH ROAD RGINIA BEACH, VA 23462		
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F 842	and resident review determinations cond (v) Physician's, nurs professional's progre (vi) Laboratory, radio services reports as This REQUIREMEN by: Based on staff interreview, the facility secomplete and accurate 25 Residents. Residents. Resident #45 a consultation report month of February record. The record review had been admitted Diagnoses included diabetes, depression bestructive pulmon Section C (cognitive admission MDS (month and ARD) (assee 02/07/18 included mental status) surpossible 15 points. The clinical record transcribed by the	ny preadmission screening evaluations and flucted by the State; se's, and other licensed ess notes; and ology and other diagnostic required under §483.50. IT is not met as evidenced triew and clinical record taff failed to maintain rate clinical records for five of dents #45, #57, #234, #48, ed. 5, the facility staff failed to file of the from the pharmacist for the in the Residents clinical revealed that Resident #45 to the facility 01/31/18. It is to the facility 01/31/1	F	842	Monitoring: The Administrator and DON are responsible for maintaining complianc. The DON, QA Nurse and/or designee conduct weekly chart audits coinciding with the Care Plan schedule to monito for compliance. Any/all negative findi will be clarified and corrected at time discovery and disciplinary action will taken as needed. The results of this au will be provided to the Quality Assura Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 25, 2018	will r r ngs of be dit ance	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY
			A. BOILDING	·		С
		495234	B. WING		0-	4/12/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
UEDITAG	- 11411 \ \#DOWN DE	201		5580 DANIEL SMITH ROAD		
HERITAGE	E HALL VIRGINIA BEA	СП		VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE
F 842	Continued From pa	age 68	F 84	12		
	and/or recommend			2.02		
		e clinical record the surveyor the results of this consult.				
	consult on 04/12/1	ed the surveyor a copy of this 8. No explanation was provided of in the clinical record.				
	1	staff was notified of this issue proximately 3:12 p.m.				
	provided the surve policy/procedure to					
	part, "All services	his policy/procedure read in provided to the residentor any sident's medical, physical,	(R)			
	functional or psychocumented in the	nosocial condition, shall be resident's medical record. The ould facilitate communication				
	between the interd	disciplinary team regarding the n and response to care"				
		ntion regarding this issue was rivey team prior to the exit				
		57, the DON (director of sign the pharmacy consultation 2018.				
	was admitted to the included but were	revealed that Resident #57 ne facility 09/26/13. Diagnoses not limited to, cerebral ner's disease, and dysphagia.				
	The state of the s	ive patterns) of the Residents inimum data set) assessment				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE S COMPL	ETED
		495234	B. WING	Harris Ha	04/1	2/2018
	ROVIDER OR SUPPLIER HALL VIRGINIA BEA	сн		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	O3/07/18 included a mental status) sum The clinical record consultation report included recommer pharmacy. The phy on 01/22/18. The libeen left blank. During an interview approximately 10:0 the surveyor that s consult but had not The administrative on 04/12/18 at app. No further informal provided to the surconference. 3. For Resident #2 document for the a and supplements of the record review was admitted to the included, but were fibrillation, osteoar and essential hyper there was no correct) assessment of the record review was admitted to the included, but were fibrillation, osteoar and essential hyper there was no correct) assessment of the record review was admitted to the included, but were fibrillation, osteoar and essential hyper there was no correct) assessment of the record review was admitted to the included, but were fibrillation, osteoar and essential hyper there was no correct.	ssment reference date) of a BIMS (brief interview for mary score of 9 of 15 points. Included a pharmacy for January 2018. This report indations from the consulting visician had signed this report the for the DON to sign had If with the DON on 04/11/18 at 15 a.m., the DON verbalized to the had reviewed the pharmacy it signed it. It staff was notified of this issue roximately 3:12 p.m. Ition regarding this issue was every team prior to the exit 34, the facility staff failed to indministration of medications on 04/06/18. If we aled that Resident #234 to facility 03/28/18. Diagnoses not limited to, chest pain, atrial thritis, functional quadriplegia, extension. In pleted MDS (minimum data in this Resident. However, the	F 84	42		
	[8]	sidents eMARs (electronic stration records) for the month				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 10 10 10 10 10 10 10 10 10 10 10 10 10		ISTRUCTION		E SURVEY PLETED
		495234	B. WNG			04	V12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н	STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 842	of 04/2018 revealed staff failed to docume miralax powder, cola zyrtec, fluticasone, composed flovent, alum-mag hypass. On 04/11/18 at approximate of the united flowers and the united flowers and the united flowers and the united flowers and the united flowers and flowers and flowers and flowers and had to leave wo not hit the final button administered and proving an interview of 04/11/18 at approximated she had recently flowers and	that for 04/06/18 the nursing ent for the administration of ice, klor-con, furosemide, ardizem, protonix, lopressor, ydroxide, pro-stat, and med eximately 2:25 p.m., the tranager reviewed the enterthis review, the unit would review the clinical eximately 3:10 p.m., LPN enterthis with a copy of their enterthis were epared. With Resident #234 on mately 3:45 p.m., the Resident ived all her medications. Staff was notified of this issue eximately 3:12 p.m. Ference, the facility staff or with a copy of their	F	842			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	207 (\$00000000000000000000000000000000000	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED C	
		495234	B. WING_			0/	4/12/2018
	ROVIDER OR SUPPLIER HALL VIRGINIA BEAC	н		5580	EET ADDRESS, CITY, STATE, ZIP CODE DIDANIEL SMITH ROAD GINIA BEACH, VA 23462	32	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU! CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 842	provided to the surve conference. 4. The facility staff far alarm that was order safety on the Decemmedication administration record. The clinical record of 4/9/18 through 4/12/admitted to the facility that included but not disease, dementia war major depressive disthrive, and history of Resident #48's quar (MDS) assessment reference date (ARC resident with long-te short-term memory impaired cognitives No identified indicate behaviors. The surveyor review physician order shence 12/5/17 read "Resident with long-te short-term memory impaired cognitives of the surveyor review physician order shence the surveyor review physician order shence the surveyor review physician order shence the surveyor review through April 2018 eadministration record.	ordmedication In regarding this issue was ey team prior to the exit ailed to document the clip and to be worn at all times for other 2017 through April 2018 ration record/treatment at for Resident #48. If Resident #48 was reviewed as. Resident #48 was aty 11/28/17 with diagnoses, at limited to Alzheimer's with behavioral disturbances, acrder, anxiety, adult failure to a falling. Iterly minimum data set with an assessment and of 3/5/18 assessed the arm memory problems, problems, and moderately kills for daily decision-making. Are the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017 and the December 2017	F	842			
	(MDS) assessment reference date (ARD resident with long-te short-term memory impaired cognitive s No identified indicate behaviors. The surveyor review physician order shen 12/5/17 read "Resid times for safety." The surveyor review through April 2018 administration recorn evidence the treatments.	with an assessment b) of 3/5/18 assessed the erm memory problems, problems, and moderately kills for daily decision-making. ors of psychosis, delirium, or wed the December 2017 et. The physician order dated ent to wear a clip alarm at all wed the December 2017 electronic treatment rds (eTAR) but found no					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	21 TO 12 2 SEA SEA SEA SEA SEA SEA SEA SEA SEA SEA		STRUCTION	5 200 1000 1000	TE SURVEY MPLETED
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rowner seed	ROVIDER OR SUPPLIER HALL VIRGINIA BEA	СН		5580 D	T ADDRESS, CITY, STATE, ZIP CODE ANIEL SMITH ROAD NIA BEACH, VA 23462		
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F 842		vear a clip alarm at all times for	F	842			
	December 4 had ** documentation. Af	ter 12/4/17, each box was through 12/31/17. The same					
	nurse on 4/10/18 a inability to locate d the clip alarm. The	med the corporate registered t 3:53 p.m. of the surveyor's ocumentation of the order for e corporate RN stated the "clip y and it would be charted in an					
20		med the administrator and the of the above concern on n.					
	"Medication Error director of nursing was entered on the time code was not	rveyor was provided a Report" dated 4/10/18 from the . The DON stated the order e eTAR but a time interval or . The DON stated there was me to the resident.					
	documentation title Documentation" o part "2. The follow	n 4/12/18. The policy read in ving information is to be e resident medical record: c.					
	No further information exit conference or	ation was provided prior to the n 4/12/18.					
	ordered treatment	ff failed to document physician ts to the right inner thigh of 6/26/17 and 6/27/17.					

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMI	(X3) DATE SURVEY COMPLETED C		
		495234	B. WING_	_	04	/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	СН		STREET ADDRESS, CITY, STATE, ZIP C 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 842	The clinical record of 4/11/18 through 4/1 admitted to the facil 5/20/16 and dischard diagnoses included obesity, acute embe extremity, hyperten hyperlipidemia, trar attacks, flaccid herr mellitus, chronic kiddementia, aphasia, tract infection, cogrexpressive language. Resident #87's qual (MDS) assessment reference date (AR resident with a BIM There were no indicor behaviors affection. Resident #87 was for bed mobility, trapersonal hygiene, Resident #87 requiperson for eating, of motion was asse extremities on one frequently incontinincontinent of bow to be at risk for the No pressure ulcers.	of Resident #87 was reviewed 2/18. Resident #87 was ity 10/9/14, readmitted ged 7/3/17. Resident #87's but not limited to morbid olism and thrombosis of lower sion, dysphagia, esient cerebral ischemic hiplegia, pain, Type 2 diabetes liney disease, vascular vitamin D deficiency, urinary attive communication deficit, the disorder and severe stress. Interfy minimum data set with an assessment D) of 5/22/17 assessed the S score of 5/15 in Section C. cators of delirium, psychosis,	F	842		
	date of 10/9/14 that skin integrity r/t (re rt (right) sided wea	at read "Potential for impaired elated to) dx (diagnosis) of CVA, akness, decrease in mobility, &B (bowel and bladder), obesity,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BLILDING A. BLILDING			(X3) DATE SURVEY COMPLETED C			
		495234	B. WNG		0	4/12/2018
	ROVIDER OR SUPPLIER HALL VIRGINIA BEA	АСН	8	STREET ADDRESS, CITY, STATE, ZIP CO 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 842	infections, moistur refuses all shower incont. (incontinen pm (as needed)-cl care and barrier or with repositioning and fluid intake, m weekly, treatment oint (ointment)/por apply specialty maheels while in bed. The visual body map fluid inner visual bod	sheared area, fungal e associated skin damage, s. Approaches: Monitor for ce) q (every) 2 hrs (hours) and hange promptly-provide cream ream as ordered/needed, assist q 2 hrs and prn, encourage po ionitor skin integrity daily and as ordered, apply protective wder to skin as ordered/needed, attress as ordered, off load hap completed 6/23/17 shows thigh front. Legend on the or 99=other. Wound out Drainage=serous, small. No heasured 0.5 centimeters in (width) x 0.00 cm (depth). MD and responsible party notified weight 322 pounds. Orders id "Cleanse R (right) inner thigh all wound cleanser) pat dry, apply unding area, apply wound gel to over with allevyn foam, change by day) and prn." and July 2017 treatment cords were reviewed. The June in 6/23/17 through 6/30/17 were ind 6/27/17) where there is no at care was provided. The tes from 6/1/17 through 7/5/17 There was not a note for 6/26/17 und care provided. uested the facility policy on	F 84	2		
	[] 100 10000 ARCONOL AMERICAN	re from the administrator and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495234	B, WING		C 04/12/2018	
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н		STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462		
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F 849 SS=D	titled "Pressure Ulce Protocol" read in par shall describe and dd. Current treatments surfaces." The surveyor review documentation titled Documentation titled Documentation on 4 part "2. The followin documented in the return treatments or services." No further information exit conference on 4 Hospice Services. CFR(s): 483.70(o)(1) & long do either of the following the protocological process at the facility a Medicare-certified here in transferrial arrange for the proving the proving the proving the proving the proving the proving the proving the proving the proving for the proving the	g on 4/12/18. The policy rs/Skin Breakdown-Clinical t "2. In addition, the nurse ocument/report the following: s, including support ed the facility policy on "Charting and W12/18. The policy read in g information is to be esident medical record: c. es performed." on was provided prior to the /12/18. o)-(4) services. O-term care (LTC) facility may wing: ovision of hospice services on with one or more ospices. The provision of hospice by through an agreement with hospice and assist the ng to a facility that will ision of hospice services uests a transfer. pice care is furnished in an an agreement as specified in of this section with a hospice,	F 842		spice 8 & at form dent. ctice(s) een ents be at risk. crected at ent form	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	**************************************	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495234	B. WING			C 14/12/2018	
	ROVIDER OR SUPPLIER E HALL VIRGINIA BE	ACH	55	REET ADDRESS, CITY, STATE, ZIP CODE 80 DANIEL SMITH ROAD RGINIA BEACH, VA 23462			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 849	to individuals provide the timeliness of (ii) Have a written that is signed by a the hospice and a the LTC facility be any resident. The at least the follow (A) The services the appropriate he in §418.112 (d) of (C) The services provide based on (D) A communication we LTC facility and the that the needs of met 24 hours per (E) A provision the notifies the hospic (1) A significant of mental, social, or (2) Clinical compalter the plan of (3) A need to transfor any condition. (4) The resident's (F) A provision stresponsibility for course of hospical determination to provided. (G) An agreement responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face, meet the responsibility to face the responsibility to face, meet the responsibility to face the responsibili	dards and principles that apply riding services in the facility, and of the services. agreement with the hospice on authorized representative of the fore hospice care is furnished to exwritten agreement must set out ting: the hospice will provide. responsibilities for determining ospice plan of care as specified in this chapter. the LTC facility will continue to each resident's plan of care. tion process, including how the lill be documented between the ne hospice provider, to ensure the resident are addressed and day. at the LTC facility immediately ce about the following: thange in the resident's physical, emotional status. lications that suggest a need to care. Inster the resident from the facility	F 849	Systemic Changes: The facility policy and procedule been reviewed and no changes warranted at this time. All Licu will be inserviced by the Adm and Hospice Director on the procedure for coordinating car services with the Hospice Age residents receiving Hospice Scompliance. The DON, Q Nur Unit Managers will review all Hospice orders to ensure that has a coordinated Hospice Plafor all residents receiving Hospices. The results of these be reported to the Quality Ass Committee for review, analys recommendations for change policy, procedure, and/or prace Completion Date: May 25, 25.	s are ensed staff conicy and re and ency for all ervices. maintaining rse and/or l physician the facility an of Care spice audits will surance sis, & in facility ctice.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495234	B, WING		0.	4/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	н		STREET ADDRESS, CITY, STATE, ZIP COD 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462)E)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 849	representative, and provided is appropriatesident's needs. (H) A delineation of including but not limit direction and manage counseling (including bereavement); social supplies, durable mencessary for the passociated with the conditions; and all onecessary for the calliness and related of (I) A provision that the personnel are responsible therapper of prescribed therapper delineated in the hotality personnel method by the LTC facility. (J) A provision statistic report all alleged via mistreatment, negleand physical abuse source, and misapped by hospice personnel administrator immediates becomes aware of (K) A delineation of hospice and the LTC bereavement services \$483.70(o)(3) Each provision of hospice agreement must delineated.	the hospice's responsibilities, ited to, providing medical pement of the patient; nursing; g spiritual, dietary, and all work; providing medical edical equipment, and drugs alliation of pain and symptoms terminal illness and related ther hospice services that are are of the resident's terminal conditions. When the LTC facility ensible for the administration pies, including those therapies iate by the hospice and spice plan of care, the LTC ay administer the therapies State law and as specified by the thospice of unknown propriation of patient property ele, to the hospice diately when the LTC facility the alleged violation. In the responsibilities of the	F8	49		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	All Comments	IPLE CONSTRUCTION			SURVEY PLETED C 112/2018
	ROVIDER OR SUPPLIER HALL VIRGINIA BEAC		STREET ADDRESS, CITY, STATE, ZIP CO 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462				
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F 849	coordinate care to the LTC facility staff and interdisciplinary tear clinical background, scope of practice ac assess the resident that has the skills at resident. The designated interesponsible for the (i) Collaborating wir and coordinating LT the hospice care play residents receiving (ii) Communicating and other healthcar provision of care for conditions, and other for care for the patien (iii) Ensuring that the with the hospice meattending physician participating in the as needed to coordinating the form the patient. (B) Hospice election (C) Physician certification illness (D) Names and copersonnel involved patient.	pice representatives to the resident provided by the thospice staff. The m member must have a function within their State st, and have the ability to or have access to someone and capabilities to assess the ardisciplinary team member is following: th hospice representatives and the participation in anning process for those these services. with hospice representatives are providers participating in the are the terminal illness, related are conditions, to ensure quality and family. The LTC facility communicates and other practitioners are provision of care to the patient and the hospice care with the and by other physicians. Tollowing information from the and hospice plan of care specific and form. The fication and recertification of specific to each patient. That information for hospice in hospice care of each	F	849			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	DESCRIPTION OF THE PROPERTY OF	PLE CONSTRUCTION IG	0	TE SURVEY APLETED C 4/12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	ен		STREET ADDRESS, CITY, STATE, ZIP COD 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	E	
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F 849	each patient. (G) Hospice physica any) orders specific (v) Ensuring that the orientation in the pofacility, including parand record keeping furnishing care to LT §483.70(o)(4) Each care under a writter each resident's writthe most recent hos description of the sefacility to attain or in practicable physical well-being, as required to coordinate hospical residents (Resident The findings included 1. The facility staff documentation was Resident #48. The clinical record 4/9/18 through 4/1: admitted to the fact that included but in disease, dementia	an and attending physician (if to each patient. a LTC facility staff provides licies and procedures of the tient rights, appropriate forms, requirements, to hospice staff TC residents. LTC facility providing hospice a agreement must ensure that ten plan of care includes both spice plan of care and a ervices furnished by the LTC maintain the resident's highest limited at §483.24. AT is not met as evidenced review, the facility document review review, the facility staff failed ce services for 2 of 25 at 448 and Resident #86). ed: failed to ensure hospice in the clinical record of of Resident #48 was reviewed 2/18. Resident #48 was illity 11/28/17 with diagnoses, ot limited to Alzheimer's with behavioral disturbances, disorder, anxiety, adult failure to	F.8	349		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		COMPLETED	
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F 849	Resident #48's quar (MDS) assessment reference date (ARI resident with long-te short-term memory impaired cognitive s No identified indicate behaviors. Section Procedures and Procedures and Procedures and Procedures that read "Resupon admission-date #48's current comproblem of hospice date when implemed. The surveyor review 4/11/18. The hospice Hospice Services mitems provided to a directly or under arreasonable and neon management of the illness and related of Plan of Care. 2. Duties and Oblig Hospice-Coordination ensure the continuity and their families in the responsible for conferences, period assessments and early bereavement of patients and their fadesignate a member of the illness and their fade	terly minimum data set with an assessment of of 3/5/18 assessed the sem memory problems, problems, and moderately kills for daily decision-making. For of psychosis, delirium, or O Special Treatments, agrams was coded for hospice of through April 2018 had esident under hospice care and 12/28/17)." Resident rehensive care plan had the but the entry did not have a inted, goals or approaches. The decentract read in part "1.6 heans those services and Hospice Patient, either rangements that are esessary for the palliation and Hospice's patient's terminal conditions, as specified in the	F 849			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\$100 CK (100 CK (100 CK)	(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED
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F 849	the facility. Hosp following informar Patient residing a Hospice Plan of 6 form and any add Physician Certific the terminal illnes information for Hof the Hospice Plancess Hospice access Hospice medicat Physician and at 4. Coordination of Facility and Hospicality and Hospicality services agreement in acceptant in acceptant in acceptant procedures, law and regulation Medicaid program Hospice will each applicable laws a confidentiality of available to each copying, detailed each Hospice Patient Hospice patient The clinical reconstruction of Period was dated The surveyor for care-frequency of certified nursi	page 81 sice shall provide Facility with the stion specific to each Hospice at facility: (i) The most recent Care; (ii) The Hospice election ranced directives; (iii) The sation and recertification (s) of se; (iv) The names and contact ospice staff involved in the care attent; (v) Instructions on how to se 24 hour-on-call system; (vi) son information; and (vii) Hospice tending physician orders. If Services-4.4 Clinical records be and detailed clinical records. Hospice patient receiving and Hospice services under this cordance with prudent procedures, their own policies and applicable federal and state ons and applicable Medicare and maintain and subject to and regulations regarding patient information, make to other for inspection and if such clinical records concerning attent as necessary for the proper ening, and provision of services and contained a copy of the forminal Illness-60 -Day Benefit de 1/19/18 and ending 3/19/18. Und no current hospice orders for of skilled nurse visits, frequency and gaides visits, social worker haplain frequency visits. The	F8	49		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 849	surveyor was unable nursing aide visits, che worker visits in the classification of the surveyor interviel licensed practical nurp.m. about the aide vicensed practical nurp.m. about the aide vicensed practical nurp.m. about the aide vicensed the stated the faresident baths/care. Stated she would call Resident #48's visit in the surveyor informed director of nursing ar nurse of the above of documentation from the end of the day mip.m. No further information exit conference on 4/2. The facility staff fareservices for Resident Resident #86 was read 10/19/17 with the foll limited to anemia, his dementia, seizure discontinuous d	to locate any certified haplain visits and social inical record. wed the unit manager se #1 on 4/10/18 at 2:58 isits. The unit manager cility staff provided the The unit manager LPN #1 the hospice agency and get information. ed the administrator, the individual decisions agency during eeting on 4/10/18 at 4:55 In was provided prior to the 1/12/18. Is alied to coordinate hospice it #86. admitted to the facility on owing diagnoses of, but not gh blood pressure, stroke, sorder and anxiety disorder. ange MDS (Minimum Data is sessment Reference Date) dent was coded as having the rem memory problems. The ded as being moderately laily decisions. Resident indent on 1 staff member for	F 84	49		

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	6 16	G	COMPLETED
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F 849	was noted by the sudated for 10/24/17, The surveyor review noted the only docu Hospice was a Plan According to the Plareceive the following times a week for 14 Worker visits 10/22 week, then 1 time a Hospice aide visits for 12 weeks, then of 1 week. There we these visits from eaclinical record when On 4/12/18 at 3:12	rformed by the surveyor. It inveyor a physician order which stated, "Hospice Care". We the clinical record and mentation in the record from of Care dated for 10/21/17. In of Care, the resident was to g: Skilled Nursing visits 2 weeks, Medical Social (17 then 1 time a week for 1 week for 11 weeks, and 10/22/17 then 3 times a week decrease to 2 times a week was no documentation of ch of the disciplines in the a reviewed by the surveyor.	F	49	
F 880 SS=D	surveyor prior to the infection Prevention CFR(s): 483.80(a)(§483.80 Infection C The facility must estinfection prevention designed to provide comfortable environdevelopment and to diseases and infection program. The facility must estimate the infection program.	control tablish and maintain an and control program a safe, sanitary and ment and to help prevent the cansmission of communicable	F	Corrective Action(s): Resident #136 has had his nebu and tubing changed and it is no properly per facility policy and An Incident & Accident form we completed for this incident. The Clean Linen cart on the Ro Unit was removed from the unicleaned, the linen was removed linen was placed back on the cleart and returned to unit.	w stored procedure. vas se Garden t and L, and clean

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	il in the second		ONSTRUCTION	* · · · · ·	ATE SURVEY DMPLETED
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1	ROVIDER OR SUPPLIER E HALL VIRGINIA BEAC	<u> </u>		558	REET ADDRESS, CITY, STATE, ZIP CODE 50 DANIEL SMITH ROAD RGINIA BEACH, VA 23462		50072 500
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F 880	reporting, investigating and communicable of staff, volunteers, visit providing services undergraphener based conducted according accepted national stage of the pout are not limited to (i) A system of survergraphener before the persons in the facilit (ii) When and to who communicable disease reported; (iii) Standard and tratto be followed to pre (iv) When and how is resident; including to (A) The type and dudepending upon the involved, and (B) A requirement the least restrictive posticicumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact will transmit (vi) The hand hygier	em for preventing, identifying, and, and controlling infections liseases for all residents, tors, and other individuals ander a contractual upon the facility assessment to \$483.70(e) and following andards; In standards, policies, and rogram, which must include, or eight and to the standards of the second to	F	880	Identification of Deficient Practice Corrective Action(s): All residents receiving nebulizer treatments may have potentially bee affected. License staff will conduct rounds to monitor for proper infectic control practices and storage of all nebulizer equipment. Any negative findings will be corrected at time or discovery. An incident & accident will be completed for each negative finding. All Clean linen carts are now remo from the unit hallways after resider care has been provided to prevent contamination from residents remolinen from the carts. Systemic Change(s): The facility policy and procedure here in the facility policy and procedure had no changes are warranted at this time. Staff will be inserviced on the infection control and procedure and the proper clear and storage of all oxygen and nebe equipment. As well as, the proper and removal of the clean linen car ADL cart is performed on residen DON. Monitoring: The DON is responsible for main compliance. The QA Program in an audit tool for monitoring compared to the QA Committee for analysis, and recommendations for change in facility policy, procedured, or practice. Completion Date: May 25, 2018	en daily ion f f form e oved nt ADL oving has e l policy ning ulizer storage rts after ats by the staining cludes pliance, ee will or for ts will be or review, for ure,	

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10 290,47		STRUCTION		E SURVEY IPLETED
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F 880	identified under the corrective actions to \$483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual. The facility will con IPCP and update to This REQUIREME by: Based on observation document review, facility staff failed to guidelines for 2 of Resident #136). The findings included to the facility staff facemask was clearly the surveyor revier record 4/9/18 throwas admitted to the that included but rurinary tract infect pulmonary disease bursitis, morbid ob osteoarthritis, gas apnea, depressive anemia, and veno	stem for recording incidents ifacility's IPCP and the aken by the facility. Indie, store, process, and as to prevent the spread of review. duct an annual review of its heir program, as necessary. NT is not met as evidenced Ition, staff interview, facility and clinical record review, the ofollow infection control 25 residents (Resident #34 and Ided: If failed to ensure the nebulizer an for Resident #136. It weed Resident #136. It weed Resident #136 is clinical ugh 4/12/18. Resident #136 It is facility 4/1/18 with diagnoses and limited to hypertension, ion, chronic obstructive a, radiculopathy, trochanteric besity, right artificial hip joint, trointestinal hemorrhage, sleep a disorder, iron deficiency us thrombosis and embolus.	F	880			
	Resident #136's a (MDS) had not ye	dmission minimum data set t been completed.			<u></u>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		<u> </u>	(X3) DAT COM	E SURVEY IPLETED C
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F 880	Continued From pag	e 86	F	880			
	initial tour on 4/9/18 was observed in bed nightstand, the survey machine with a facel facemask was lying facemask was not so. The surveyor inform of the above concert. The unit manager Limask should be stored to 1/10/18 at 10:38. The surveyor inform corporate registered on 4/10/18 at 4:55 p.m. policy on equipment administrator stated policy that specified. The surveyor review "Oxygen Administrator stated policy that specified. The surveyor review "Oxygen Administrator stated policy that specified. The surveyor review "Oxygen Administrator stated policy that specified. The surveyor review "Oxygen Administrator stated in part "Steps if facemask, tank, hur they are in good wo fastened. 10. Oxyg should be stored in when not in use." No further informatic exit conference on 4.	ed the unit manager LPN #1 ns on 4/10/18 at 8:36 a.m. PN #1 stated the nebulizer red in a clean plastic bag. ed the administrator and the nurse of the above concerns a.m. red the administrator and the fithe above concern on and requested the facility maintenance. The the facility did not have a cleaning of the equipment. red the facility policy titled tion" on 4/11/18. The policy in the Procedure 6. Check the midifying jar, etc., to be sure whing order and are securely en tubing, cannula/mask a clean, clear plastic bag on was provided prior to the 4/12/18. failed to ensure infection					
		vere maintained on the Rose lent #34 was observed					

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	44 200400000000000000000000000000000000	IPLE CONSTRUCT		(X3) DATE COMP	
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	OVIDER OR SUPPLIER HALL VIRGINIA BEACI			5580 DANIEL S	ESS, CITY, STATE, ZIP CODE SMITH ROAD ACH, VA 23462		12/2018
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F 880	cart on 4/11/18 at 4:2 observed removing licensed practical nur UM LPN #1 stated the with the linen cart. The resident from the line informed the surveyor had been removed at and the cart replaced. The surveyor informed director of nursing an nurse of the above in during the end of the 5:15 p.m. and again of the surveyor reviewer program with the director with the director of nursing an nurse of the above in during the end of the 5:15 p.m. and again of the surveyor reviewer program with the director of nursing an nurse of the above in during the end of the 5:15 p.m. and again of the surveyor reviewer program with the director of nursing an admitted that the surveyor reviewer program with the director of the surveyor reviewer program with the director of the surveyor reviewer program with the director of the surveyor reviewer program with the director of the surveyor reviewer program with the director of the surveyor reviewer program with the director of nursing an nurse of the above in during the above in during the above in during the surveyor reviewer program with the director of nursing an nurse of the above in during the above in during the above in during the end of the surveyor reviewer program with the director of nursing an nurse of the above in during the a	from the linen cart. ad Resident #34 at the linen 9 p.m. Resident #34 was nen from the linen cart. The py the unit manager are #1 who intervened. The resident never messes are UM LPN #1 removed the n cart. The UM LPN #1 rethe linens from the cart and washed, the cart cleaned with clean linens. ad the administrator, the did the corporate registered fection control concerns day meeting on 4/11/18 at on 4/12/18 at 3:12 p.m. and the infection control actor of nursing on 4/12/18. Initted to the facility 12/4/14 included but not limited to peripheral vascular disease, ates mellitus, depression, accident. Quarterly DS) with an assessment sed the resident with roblem, long-term memory ately impaired cognitive skills	F	380			
F 924 SS=D	exit conference on 4/	12/18.	F	924			

	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE : A. BUILDING (X3) DATE :						
		NA PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY AND ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE PROPERTY ADDRESS OF THE		AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII AVIII A		C	3
65 35337755	8	495234	B. WING_			04/	12/2018
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEACI	1		558	REET ADDRESS, CITY, STATE, ZIP CODE 30 DANIEL SMITH ROAD RGINIA BEACH, VA 23462		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 924	handrails on each sid This REQUIREMENT by: Based on observation facility staff failed to eaffixed and in good re. The rose garden unit. The findings included On 04/11/18, the surn handrails (two) between urse's station were allowing the handrails resting or pushing on between the laundry shop was cracked in On 04/11/18, the surn handrail between roo station. This handrail When looking at the lobserved that some of handrail and the wall handrail in the same braces and was able wall. Maintenance en handrails. On 04/12/18 at 10:07 the handrails to see it modifications had between checking other observed the handrails.	ornidors with firmly secured le. Is not met as evidenced on and staff interview, the ensure handrails were firmly epair on one of two units. I. I. I. I. I. I. I. I. I.	FS	024	F924 Corrective Action(s): The handrails identified during the surve on the Rose Garden Unit have been repaired. Identification of Deficient Practice(s) and Corrective Action(s): All other unit handrails had the potential to be affected. The Maintenance director will inspect all handrails throughout the entire facility to identify areas at risk. Any/All negative findings will be corrected at time of discovery. Systemic Change(s): The facility policy & procedure for providing a safe, sanitary, and comfortable environment was reviewed and no changes are warranted at this tim All staff will be inserviced on reporting and recording maintenance request form for items including handrails that need repair or replaced. The environmental services staff will inspect hand rails dai as part of their daily cleaning process throughout the building. Any/all negative findings will be reported to the maintenance director for repair. Monitoring: The Maintenance Director is responsible for maintaining compliance. The Maintenance Director and/or designee will complete the facility maintenance audit tool monthly to monitor complian The results of these audits will be reported to the Quality Assurance Committee for review, analysis, recommendations for change in facility policy, procedure, and/or practice. Completion Date: May 25, 2018	l r ly ve e ce.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495234	B. WNG			С	
	ROVIDER OR SUPPLIER E HALL VIRGINIA BEACI		b. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462	(04	<i>i</i> 12/2018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	2004 T T T T T T T T T T T T T T T T T T	OULD BE	(X5) COMPLETION DATE	
F 924	The surveyor was about the hallway where the were noted. The nurse consultant with the handrails on The administrative stregarding the handra approximately 3:12 p	le to observe Residents in e issues with the handrails was notified of the issues 0412/18 at 10:10 a.m. aff was notified of the issues ils on 04/12/18 at	F	924			