PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IN COMMONDATION	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405274			С
CHANG A THEORY	ROVIDER OR SUPPLIER E HALL-RICH CREEK	495371	B. WNG	STREET ADDRESS, CITY, STATE, ZIP CO 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	01/28/2019 DE
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION BE APPROPRIATE DATE
E 000	Initial Comments		E 0	00	
F 000	survey was conducte 01/28/19. The facilit compliance with 42 of Requirement for Lor	y was in substantial CFR Part 483.73, ng-Term Care Facilities. as investigated during the	FO	00	
	survey was conduct Three complaints we survey. Corrections	gray Automotic School (Automotic State Sta			
F 622	117 at the time of the sample consisted of and 5 closed record Transfer and Discha	arge Requirements	F	S22 Corrective Action(s):
SS=C	§483.15(c) Transfer §483.15(c)(1) Facilit (i) The facility must remain in the facility discharge the reside (A) The transfer or resident's welfare a cannot be met in the (B) The transfer or of because the resident sufficiently so the re- services provided by	r and discharge- ty requirements- permit each resident to r, and not transfer or ent from the facility unless- discharge is necessary for the nd the resident's needs e facility; discharge is appropriate nt's health has improved esident no longer needs the		The facility staff provide the receive with the appropriate mation related to contact information attending physicial information for the Representative, Addirective information special instruction precautions for or comprehensive care and all other necessity.	failed to ring hospital ate inforthe transfer, on for the an, contact are Resident dvance tion, any ons or agoing care, at plan goals

Jeremich Finh Administrator 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.

2-13-19

Facility ID: VA0206

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	GD104 WXXXXX		CONSTRUCTION	(X3) DATE S	
		Wildels Total seek above 19 and the company of a 19 and 19	A. BUILD				.
		495371	B. WING			165	28/2019
NAME OF P	ROVIDER OR SUPPLIER		19000	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				12	20 OLD VIRGINIA AVENUE		
HERITAGI	E HALL-RICH CREEK			R	ICH CREEK, VA 24147	4704	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	0.000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 622	status of the resident (D) The health of indication otherwise be endang (E) The resident has appropriate notice, to under Medicare or Foresident who become admission to a facility resident only allowab or (F) The facility resident while the ap § 431.230 of this charge notice fror 431.220(a)(3) of this discharge or transfer or safety of the residence or safety of the residence or transfer §483.15(c)(2) Docur When the facility resident under any of in paragraphs (c)(1) section, the facility in or discharge is documedical record and	ne clinical or behavioral cividuals in the facility would ered; failed, after reasonable and o pay for (or to have paid edicaid) a stay at the facility. if the resident does not o paperwork for third party third party, including d, denies the claim and the ay for his or her stay. For a es eligible for Medicaid after of the facility may charge a sole charges under Medicaid; es to operate. For transfer or discharge the opeal is pending, pursuant to apter, when a resident right to appeal a transfer or on the facility pursuant to § chapter, unless the failure to or would endanger the health lent or other individuals in the must document the danger er or discharge would pose. Interest or discharges a of the circumstances specified (i)(A) through (F) of this must ensure that the transfer ormented in the resident's appropriate information is er receiving health care	F	622	information including the residents discharge summa and the facility failed to document the information provided to the receiving hospital for Residents #2 #104, #83, #90, #36, #115 #218, #19, #25 and #69. facility Incident & Accident Form has been completed feach resident involved. Identification of Deficient Practices/Corrective Activation and/or transferred from the facility may have been affected. The DON/design will conduct a 100% audit all residents who have be discharged and/or transferred from the facility in the 30 days to identify resident that did not have the receiving facility. A facility in the 30 days to identify resident and the facility in the 30 days to identify resident and facility. A facility facility. A facility facility. A facility policy and processions are warranted at this time. The DON and/or transferred from the facility and processions are warranted at this time. The DON and/or and/or transferred from the facility policy and processions are warranted at this time. The DON and/or	ent lon(s): larged che ee: of een erred past dents quired to the ecility will gative	e e

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	22.000.000.0000.0000.0000.0000.0000.0000	LE CONSTRUCTION	(X3) DATE SI COMPLE	
		495371	B. WNG		21.720	8/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 622	must include: (A) The basis for the (i) of this section. (B) In the case of pal section, the specific be met, facility attern needs, and the servi facility to meet the needs, and the servi facility to meet the needs, and the servi facility to meet the needs, and the section of the control of the contro	transfer per paragraph (c)(1) ragraph (c)(1)(i)(A) of this resident need(s) that cannot pts to meet the resident ce available at the receiving red(s). In required by paragraph (c) roust be made by- registration when transfer or rary under paragraph (c) (1) roustion; and retransfer or discharge is ragraph (c)(1)(i)(C) or (D) of reded to the receiving provider roum of the following: rion of the practitioner reare of the resident. rentative information including reve information rections or precautions for propriate. reare plan goals; reary information, including a red discharge summary, red d	F 6.	Regional Nurse Consinservice facility staff on the docume required to be submather receiving facilia resident is being ferred or discharge hospital or other of health care facility. Monitoring: The DON/designee wiresponsible for maicompliance. The DON designee will conduct audits weekly of all who have been dischor transferred from facility to monitor pliance. Any/all maintaines and or errorected at time of Aggregate findings audits will be reported and recommendations in facility policy, and/or practice. Completion Date: 3	licensed ntation itted to ity when trans- d to the utside y/provider. Il be ntaining N and/or oct chart l residents larged and/ the for com- legative for swill be of discovery. of these orted to the committee ew, analysis, s for change procedure,	

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 3 of 57

FEB 2 1 2019 VDH/OLC

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION	(X3) D/	NO. 0938-0391 ATE SURVEY PMPLETED
		495371	B. WING			C 01/28/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147		
(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)	N SHOULD BE	(X5) COMPLETION DATE
F 622	representative information, Advance special instructions o care, comprehensive other necessary infor the resident's dischard document information provider for 10 of 29 Resident #104, Resident #36, Resident #19, Resident #19, Resident #19, Resident #19, Resident #104 was tractional record of reviewed 1/23/19 through the series and agit femur fracture, metab tract infection, and hy Resident #104's signiset (MDS) assessment reference date (ARD)	ration including contact and Directive information, all representations for ongoing care plan goals, and all mation including a copy of a summary and failed to a provided to the receiving residents (Resident #267, Ident #83, Resident #90, Ident #81, Resident #218, Ident #25, and Resident #69). It is illed to provide the receiving tion for on-going care when ansferred to the hospital. Resident #104 was bugh 1/28/19. Resident Ident Id	F 62	2		
	p.m. read in part "She time for direct admit to	e dated 12/19/18 at 2:18 e is leaving facility at this c RGH (name of hospital d via (name of ambulance				

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000	IPLE CON	STRUCTION	1,000	SURVEY PLETED C
		495371	B. WING	. 70000		01:	/28/2019
	ROVIDER OR SUPPLIER HALL-RICH CREEK			120 O	T ADDRESS, CITY, STATE, ZIP CODE LD VIRGINIA AVENUE CREEK, VA 24147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	200	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 622	The departmental not 1/24/19. The 12/19/20 note read, "RGH (note and wanted to know did not get a report." They do have a bed (sic) at this time." The clinical record is contact information, provided to the hos information, contact transfer form, compact, or any special. The surveyor inform director of nursing.	ptes were reviewed on (18 5:32 p.m. departmental ame of hospital) nurse called why resident was there. She from this facility as to why, and she is been admitted and no documentation of what information was pital, advanced directive at representative contact tinformation from the facility, prehensive careplan goals I instructions or bed hold offer.	F	622			
	day meeting on 1/2 team asked what is residents are trans director of nursing medication adminition DON stated the factor of a form called "I completed. The simpolicy on transfers The director of nurthe policy titled "B 1/25/19. The policy and therapeutic less representatives wheel-hold and return the director of nurthe director of nurthe director of nurthe director of nurthe director of nurther director d	24/19 at 4:14 p.m. The survey information was provided when ferred to the hospital. The stated the face sheet and the stration record (MAR). The cility was just beginning to work interact" but had to be surveyor requested the facility discharges. The provided the surveyor with the ed-Holds and Returns on the cy read in part "Prior to transfers aves, residents or resident ill be informed in writing of the					

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 5 of 57

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			1	s
		495371	B. WING_			01/	28/2019
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA. 24147						
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ART TANKS	(X5) COMPLETION DATE
F 622	Continued From page on 1/28/19.	÷5	F	522	×		
	The facility staff fa #90's transfer/dischar receiving provider wh hospital on 10/29/18:	en transferred to the	100		2		
	1/23/19 through 1/28/ admitted to the facility 11/2/18 and 11/7/18 v but not limited to vaso behavioral disturbanc hypothyroidism, cervi intertrochanteric fract gastro-esophageal re scalp, chronic diastoli infarction, dysphagia,	Resident #90 was reviewed 19. Resident #61 was / 3/13/17 and readmitted with diagnoses that included cular dementia without les, type 2 diabetes mellitus, cal disc disorder, right femurure, osteoporosis, flux disease, contusion of ic heart failure, cerebral major depressive disorder, nia, hypertension, and					T.
	minimum data set (M assessment reference	cant change in assessment DS) assessment with an e date (ARD) of 1/2/19 t with a brief interview for as 7/15.	Ø				
		ted 10/29/18 read "May send gency room) for eval reatment)."			, F		
	dated 10/29/18 10:44 "Late Entry: This nurse gym. Resident was f Resident stated she I to the floor. Upon as she had pain in her ri	ed the departmental note p.m. The note read in part se was called to therapy ound in floor on right side, nad lost her balance and fell sessment resident stated ght hip and right side of her of 4 out of 10. Right side of					

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	ETED
	<u> </u>	495371	B. WING		01/2	8/2019
	ROVIDER OR SUPPLIER E HALL-RICH CREEK		120	REET ADDRESS, CITY, STATE, ZIP CODE OLD VIRGINIA AVENUE CH CREEK, VA 24147		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	assisted to wheelch (medical doctor) not concerned of reside and wanted resident omitted). Transport and resident left via Departmental note read in part "Resided A second physician" "May send out to E (treatment) due to combativeness, try decreased O2 (oxy The surveyor revied dated 11/4/18 6:46 entry 6p.m. Resided confusion with big has been very con Resident can norm conversation, but doing things to he hair, bending finge staff and stating "I you did this. You This is not normal nurse sent to ER and RP (responsinurses decision a hospital." The clinical recorresident information of the actiniormation of the surveyor of the actiniormation of the surveyor resident of the surveyor review of the surve	a present. Resident was air and to her room. MD iffied (name omitted) nt on Coumadin with the fall to be sent to ER (name arrived at 1820 (6:20 p.m.)	F 622			

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 7 of 57

PRINTED: 02/06/2019-FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY
		DENTI PORTOR HOMBER.	A. BUILDING	ATTEN ACTION	COMPLETED
		495371	B. WING		C 01/28/2019
	PROVIDER OR SUPPLIER		120	ET ADDRESS, CITY, STATE, ZIP CODE OLD VIRGINIA AVENUE H CREEK, VA 24147	1 0 1120 20 10
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 622	comprehensive care is summary/transfer for care or bed hold offer. The surveyor informe the above information record for either of Reemergency room and the hospital on 10/29/at 3:55 p.m. The dire only information sent face sheet and the mercord (MAR). The surveyor informed director of nursing and nurse of the above coday meeting on 1/24/team asked what informed in the surveyor informed director of nursing stamedication administration administration aform called "Intercompleted. The surveyor informed in the facility on a form called "Intercompleted. The surveyor informed in the surveyor informed in the facility on a form called "Intercompleted. The surveyor informed in the surveyor infor	colan goals, discharge m, or special instructions for d the director of nursing of a not found in the clinical esident #61's transfers to the subsequent admissions to 18 and 11/4/18 on 1/27/19 ctor of nursing stated the with the resident was the edication administration d the administrator, the did the corporate registered incern during the end of the 19 at 4:14 p.m. The survey fination was provided when red to the hospital. The ted the face sheet and the tition record (MAR). The y was just beginning to work fact" but had to be easy or requested the facility charges. If provided the surveyor with holds and Returns" on ead in part "Prior to transfers is, residents or resident in formed in writing of the olicy."	F 622		

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON	ISTRUCTION		E SURVEY IPLETED
		495371	B. WING		, ,	C 1/28/2019
	ROVIDER OR SUPPLIER E HALL-RICH CREEK		120 (ET ADDRESS, CITY, STATE, ZIP CODE DLD VIRGINIA AVENUE I CREEK, VA 24147		10-10-10-10-10-10-10-10-10-10-10-10-10-1
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A' DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	transfer/discharge in provider when Reside the hospital. The clinical record of reviewed 1/23/19 th #218 was admitted readmitted 1/21/19 but not limited to accellulitis of right low failure with hypercal (MDS) assessment reference date (AR resident #218's ad (MDS) assessment reference date (AR resident with a brie (BIMS) as 15/15. The clinical record room visits with two Resident #218 was on 11/24/18 for about the receiving provider. The clinical record admitted to the emerge evidence of what is receiving provider. The clinical record admitted to the house hysician discussion of the physician discussion in the provider of the physician discussion in the physicia	aformation to the receiving dent #218 was transferred to of Resident #218 was rough 1/28/19. Resident to the facility 4/6/18 and with diagnoses that included aute osteomyelitis, sepsis, er limb and chronic respiratory pnia. mission minimum data set with an assessment D) of 1/14/19 assessed the finterview for mental status revealed three emergency or requiring hospitalizations is sent to the emergency room dominal pain and constipation. The entation that a report was gency room but no further information was provided to the	F 622			

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 9 of 57

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING_ C 495371 B. WNG 01/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE HERITAGE HALL-RICH CREEK RICH CREEK, VA 24147 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 622 Continued From page 9 F 622 None of the notes dated 1/4/19 detail information sent to the receiving provider when the resident did not return to the facility on 1/4/19. The clinical record revealed Resident #218 was admitted to the hospital 1/18/19-1/21/19 for acute kidney injury. The departmental note dated 1/18/19 at 1:53 p.m. read in part "Resident complains of feeling bad. Could not state exactly what her complaints were more specifically. Did state she was having double vision and that her vision was wavey. MD (medical doctor-name omitted) notified. Telephone order received to send patient to ER (emergency room) for evaluation and treatment of complaints." The departmental note dated 1/18/19 at 2:24 p.m. read "EMS (emergency medical services) notified for transport to the ED (emergency department), report called to ED (name omitted)." The departmental note dated 1/19/19 at 10:32 a.m. read in part "Resident was admitted 1/18/19 ... for acute kidney injury." None of the transfers/discharges/hospitalizations had documentation in the clinical record of information provided to the receiving provider-contact information of the practitioner, contact information of the resident representative. transfer form, advanced directive, comprehensive care plan goals, or any pertinent information pertaining to the ongoing care of the resident or offer of bed-hold information. The survey team met with the administrator, the director of nursing (DON), and the corporate

registered nurse on 1/24/19 at 4:14 p.m. and

PRINTED: 02/06/2019

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF I		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE COMPI	
		495371	B. WING		01/3	28/2019
	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	the hospital when a The DON stated a far administration record administration record administration record administration record administration record administration record after the DON stated the work on a form called completed. The surpolicy on transfers/of The director of nurs the policy titled "Bed 1/25/19. The policy and therapeutic lear representatives will bed-hold and return. The director of nurs transfers/discharge on 1/28/19. 4. The facility staff transfer/discharge provider when Reshospital 1/11/19. The clinical record 1/23/19 through 1/23/19 through 1/23/18 with diagnot to acute and chrorn hypoxia, hypothyromajor depressive bronchitis, repeate pressure ulcer stall Resident #25's que (MDS) assessment.	e required information sent to resident was transferred. Ace sheet and a medication of (MAR). If acility was just beginning to ad "Interact" but had to be everyor requested the facility discharges. Ing provided the surveyor with deficient and Returns" on read in part "Prior to transfers eves, residents or resident be informed in writing of the inpolicy."	F	622		

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 11 of 57

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495371 B. WNG_ 01/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE **HERITAGE HALL-RICH CREEK** RICH CREEK, VA 24147 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 622 Continued From page 11 F 622 resident with a brief interview for mental status (BIMS) as 15/15. The clinical record revealed a telephone order dated 1/11/19 that read "May send out to ER (emergency room) (name of hospital omitted) for eval (evaluation)/tx (treatment) d/t (due to) fall & c/o (complaints of) pain." The surveyor reviewed the 1/11/19 6:07 p.m. departmental note. The note read in part: "@1728 (5:28 p.m.) staff stated that resident was in the floor. Resident was observed to be laying on his left side on the left side of the bed. Blood was coming from resident's head and left forearm. Pressure was held onto (sic) bleeding areas. 911 was called for transport. Resident stated that his left hip, left shoulder and head was hurting. Unable to do neuro checks due to resident's refusal. MD (medical doctor) and RP (responsible party) aware. Rescue squad arrived x3 attendants. Resident was assisted onto the stretcher x3 attendants and 2 employees. Resident left the facility at this time. Report was called to ER (emergency room) (name omitted)." The departmental note failed to have evidence of information sent with Resident #25 when the resident was transferred to the hospital-no transfer form/discharge form, contact information. resident representative contact information, comprehensive care plan goals, advanced directive, or any pertinent tests or bed hold information. The survey team had discussed the concerns with transfer/discharges and information sent with residents in the end of the day meeting on 1/24/19 at 4:14 p.m. with the administrator, the

PRINTED: 02/06/2019 FORM APPROVED

PRINTED: 02/06/2019 FORM APPROVED OMB NO 0938-0391

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			1	0000 0001
TATEMENT OF ND PLAN OF C	DEFICIENCIES ORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE S COMPL	
					0	
		495371	B. WNG	No. 10. 10. 10. 10. 10. 10. 10. 10. 10. 10	01/2	8/2019
NAME OF PRO	OVIDER OR SUPPLIER		s.	TREET ADDRESS, CITY, STATE, ZIP CO	DDE	
			1:	20 OLD VIRGINIA AVENUE		
HERITAGE I	HALL-RICH CREEK		R	ICH CREEK, VA 24147		19 1 <u>9 19 19</u>
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI	ON SHOULD BE	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO T DEFICIENC		DAIC
F 622	Continued From pag	pe 12	F 622			
10		OON) and the corporate	, A 405 - 600			
		e DON stated information	1			
	2000 E 00 (0000	nt when transferred included				
18		he medication administration		N.		
	record.	The second secon				
To the Addition	No further informatic	on was provided prior to the				
11	exit conference on 1	The Control of the Co	59			
0,4	5. There were six o	ther residents who were				
	transferred to hospit	tals and the facility staff failed				
	to provide information	on to the receiving providers.	· ·			
	Those residents we	re identified as Resident				
	#267, Resident #83	, Resident #36, Resident				
	#115, Resident #19	, and Resident #69.				
	The survey team m	et with the administrator, the				
		DON) and the corporate	3			Ì
		1/24/19 at 4:14 p.m. and				
	during the meeting	asked what information was				
	provided to the rece	eiving provider when		-		i
	transferred to the h	ospital. The DON stated the				
	face sheet and the	medication administration				
,	record were sent.	The DON stated the facility				
	was just beginning	to work on paperwork to be				1
		when they are transferred to	l l			
	the hospital. The D	ON stated the facility was				
	reviewing a form ca	alled Interact for transfers.				
	No further informat	tion was provided prior to the				
1	exit conference on	55 Control (1985) 1 (
F 623	Notice Requirement	nts Before Transfer/Discharge	F 62	Corrective Action	1(5):	
SS=C	CFR(s): 483.15(c)((3)-(6)(8)	1	Resident #104's r		
93 CONTRACTOR (1982 1885 1885 1885 1885 1885 1885 1885 1885 1885 1885 1885 1885 1885				party has been no		
	§483.15(c)(3) Notic	ce before transfer.				
	Before a facility tra	ansfers or discharges a		the facility fail		1
	resident, the facility			a discharge/trans		
	(i) Notify the reside	ent and the resident's	1	to the resident a		
l.			No. over	sible party for t	he resident's	5

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 13 of 57

PRINTED: 02/06/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 495371 B. WNG 01/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE HERITAGE HALL-RICH CREEK RICH CREEK, VA 24147 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 13 F623 transfer to the hospital on representative(s) of the transfer or discharge and 12/19/18 and the facility failed the reasons for the move in writing and in a to document in the medical language and manner they understand. The record the Ombudsman notifaction facility must send a copy of the notice to a of the discharge. representative of the Office of the State Long-Term Care Ombudsman. Resident #90's responsible (ii) Record the reasons for the transfer or discharge in the resident's medical record in party has been notified that accordance with paragraph (c)(2) of this section; the facility failed to provide a discharge/transfer notice to (iii) Include in the notice the items described in the resident and the Responparagraph (c)(5) of this section. sible party for the resident's transfer to the hospital on §483.15(c)(4) Timing of the notice. 10/29/18 & 11/4/18 and the (i) Except as specified in paragraphs (c)(4)(ii) and facility failed to document in (c)(8) of this section, the notice of transfer or the medical record the Ombudsdischarge required under this section must be man notification of the dismade by the facility at least 30 days before the charge. resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when-Resident #218's responsible (A) The safety of individuals in the facility would party has been notified that be endangered under paragraph (c)(1)(i)(C) of the facility failed to provide this section; a discharge/transfer notice to (B) The health of individuals in the facility would the resident and the Responbe endangered, under paragraph (c)(1)(i)(D) of sible party for the resident's this section: transfer to the hospital on (C) The resident's health improves sufficiently to 11/24/18, 1/4/19 & 1/18/19 and allow a more immediate transfer or discharge. the facility failed to document under paragraph (c)(1)(i)(B) of this section: (D) An immediate transfer or discharge is in the medical record the required by the resident's urgent medical needs, Ombudsman noticication of the under paragraph (c)(1)(i)(A) of this section; or discharge. (E) A resident has not resided in the facility for 30 days. Resident #25's responsible party has been notified that §483.15(c)(5) Contents of the notice. The written the facility failed to provide

notice specified in paragraph (c)(3) of this section

a discharge/transfer notice to

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLANCE	CONTROL	considerated Annex Annex on the Standard Review of the Standard Revi	900 00 0 7 Ye 20 Y 750 00 00 00 00 00 00 00 00 00 00 00 00 0		С
		495371	B. WING	<u> </u>	01/28/2019
	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE 20 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	N
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 623	(iii) The location to value transferred or dischalicity A statement of the including the name, and telephone number to obtain an appeal completing the form hearing request; (v) The name, additelephone number of Long-Term Care Or (vi) For nursing faction and developmental disabilities, the main telephone number of the protection and developmental disabilities, the main telephone number of the Developmental disabilities, the main developmental disabilities, the main telephone number of the Developmental disabilities,	ansfer or discharge; ansfer or discharge; which the resident is arged; ne resident's appeal rights, address (mailing and email), per of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and of the Office of the State in and submitting the appeal ess (mailing and email) and of the Office of the State inbudsman; lity residents with intellectual disabilities or related ling and email address and of the agency responsible for advocacy of individuals with abilities established under Part ental Disabilities Assistance ct of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and telephone number of the effor the protection and duals with a mental disorder the Protection and Advocacy widuals Act. Inges to the notice. In the notice changes prior to fer or discharge, the facility ecipients of the notice as soon et the updated information	F 623	to the resident and the Resible party for the resident ansfer to the hospital 1/11/19 and the facility to document in the medical record the Ombudsman notication of the discharge Residents #287, #83, #36, #19, and #69, s responsible party has been notified to the facility failed to provide a discharge/transfer notified the resident and the Responsible party for the resident and the facility failed to do in the medical record the facility failed to do in the medical record the facility failed to do in the medical record the medical record the facility may have been and/or transferred from facility may have been and/or Admissions Direct conduct a 100% audit of residents who have been charged and/or transferred the past 30 days. Residuentified at risk will corrected at time of disand the required notification the residents' responsible to the resident and the required notification of the resident and the resident and the resident and	dent's on failed al #115, ee that covide to to condent's and ocument he the the fected. Ector cor will all discred in dents be scovery cations

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 15 of 57

NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK SUMMARY STATEMENT OF DEFICIENCIES OX4) ID PREFIX RICH CREEK SUMMARY STATEMENT OF DEFICIENCIES RICH CREEK, VA 24147 PRODUCTION OR LS DEDITION NOTES DENISTRANCE MOTEOMATION AT SUMMARY STATEMENT OF DEFICIENCY MAY BE PRECEDED BY FULL PREFIX TAB PROVIDERS FLAN OF CORRECTION SHOULD BE CONSERVE REPRESON TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CONSERVE REPRESON TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CONSERVE REPRESON TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CONSERVE REPRESON TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CONSERVE REPRESON TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CONSERVE REPRESON TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CROSS REPRESONED TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CROSS REPRESONED TO THE APPROPRIATE CONSERVE REPRESON TO THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE DEFICIENCY OF THE APPROPRIATE SHOULD BE CROSS REPRESONED TO THE APPROPRIATE CONSERVE REPRESON TO THE APPROPRIATE CONSERVE		OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, JIP CODE 120 CID VIRININA ARABURE TAG			495371	B. WNG	B. WNG		С	
HERITAGE HALL-RICH CREEK 120 CLO VARGINA AVENUE RICH CREEK, VA. 24147	NAME OF P	PROVIDER OR SUPPLIER	1 400011				1/28/2019	
FREFIX TAG EGULATORY OR ISC IDENTIFYING INFORMATION F 623 Continued From page 15 \$483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Long-Term Care Ornbudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on staff interview, facility document review and clinical record review, the facility staff failed to provide written notice of transfer or discharge; the location to which the resident is transferred or discharged; a statement of the residents appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ornbudsman and documentation in the medical record that the notice was sent to the Ombudsman for 10 of 29 residents (Resident #207, Resident #104,		a translation of the state of t	e e		120 OLD VIRGINIA AVENUE			
SAB3.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(i). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide written notice of transfer/discharge to include the effective date of transfer of include the effective date of transfer of cischarge; the location to which the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests, and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request, the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman and documentation in the medical record that the notice was sent to the Ombudsman for 10 of 29 residents (Resident #287, Resident #104,	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETION	
Resident #83, Resident #90, Resident #36, Resident #115, Resident #218, Resident #19, Resident #25, and Resident #69). The findings included: 1. The facility staff failed to provide written notice of transfer to the resident and the resident representative when Resident #104 was Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate	F 623	§483.15(c)(8) Notice In the case of facility the administrator of the written notification prior to the State Survey A State Long-Term Care the facility, and the rewell as the plan for the relocation of the residus. 70(l). This REQUIREMENT by: Based on staff interviand clinical record revito provide written notification to which the location the loc	in advance of facility closure closure, the individual who is the facility must provide for to the impending closure gency, the Office of the elements of the facility document review view, the facility staff failed die of transfer/discharge to the element of the resident is transferred or the element of the entity which the elements of the entity which the element of the entity which the element of the office of the Office of the element of the Office of the	F 62	will be made. A fa Incident & Accident be completed for ea finding. Systemic Change(s): Facility policy and have been reviewed. ions are warranted time. The Administ or Regional Nurse C will inservice the social worker(s), nadministration and I staff on the dischatransfer requirement to be given to the and resident's respparty and that the ombudsman will be noresident discharges Monitoring: The Social Services will be responsible taining compliance. worker, and/or Administration will conduct audits weekly of all who have been discharged from facility. Any/all indings and or errocorrected at time or corrected at time or services and the contract of the corrected at time or corrected at time o	procedures No revisat this rator and/ consultant facility's ursing icensed rge and ts that are resident onsible state otified of /transfers. Director for main— The Social ssions ct chart l residents arged and/ the negative ors will be f discovery		

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C 01/28/2019	
		495371	B. WING_				
NAME OF P	ROVIDER OR SUPPLIER	100011		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1	
	E HALL-RICH CREEK				O OLD VIRGINIA AVENUE CH CREEK, VA 24147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	transferred to the ho in the medical record of reviewed 1/23/19 the #104 was admitted to readmitted 1/2/19 who but not limited to hypothemical disturbar restlessness and agreement fracture, metatract infection, and the Resident #104's sign set (MDS) assessment reference date (AR resident with a brief (BIMS) as 4/15. The departmental report p.m. read in part "Stime for direct adminimental in part "Stime for direct adminimental in p.m. read, "RGH (reand wanted to know did not get a report They do have a be (sic) at this time." The clinical record written notice of trained the resident resid	spital and failed to document d ombudsman notification. f Resident #104 was rough 1/28/19. Resident to the facility 12/10/18 and lith diagnoses that included pokalemia, dementia with nees, atrial fibrillation, pitation, insomnia, infected left abolic encephalopathy, urinary hypertension. Inificant change minimum data lient with an assessment D) of 1/9/19 assessed the finterview for mental status Inote dated 12/19/18 at 2:18 the is leaving facility at this it to RGH (name of hospital ted via (name of ambulance	F	523	findings of these audits be reported to the Qualit Assurance Committee quart for review, analysis, and recommendations for chang facility policy, procedurand/or practice. Completion Date: 3/12,	terly di	

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 17 of 57

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		405074) (6	0202			С
NAME OF	PROVIDER OR SUPPLIER	495371	B. WING			01.	28/2019
	E HALL-RICH CREEK		eg eg	120	EET ADDRESS, CITY, STATE, ZIP CODE OLD VIRGINIA AVENUE H CREEK, VA 24147		es.
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 623	The surveyor inform director of nursing a nurse of the above day meeting on 1/2 team asked what in residents are transf director of nursing a medication adminis DON stated the factor of nursing semigration on a form called "In completed. The supplicy on transfers/of the director of nursing the policy titled "Be 1/25/19. The policy and therapeutic lear representatives will bed-hold and return. The director of nursitransfers/discharge on 1/28/19. 2. The facility staff of transfer to the representative when transferred to the hill/4/18 and failed record ombudaman. The clinical record of 1/23/19 through 1/2 admitted to the facility and 11/7/18 but not limited to value behavioral disturbations.	ned the administrator, the and the corporate registered concern during the end of the 4/19 at 4:14 p.m. The survey formation was provided when terred to the hospital. The stated the face sheet and the tration record (MAR). The illity was just beginning to work teract" but had to be reveyor requested the facility discharges. In provided the surveyor with de-Holds and Returns" on read in part "Prior to transfers was, residents or resident be informed in writing of the informed in writing of the policy." In gdid not provide a policy for sprior to the exit conference failed to provide written notice sident and the resident notice and to document in the medical notification. of Resident #90 was reviewed 8/19. Resident #90 was reviewed 9/19. Resident #90 was	F	523			

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE &	MEDICAID SERVICES				NO. 0938-0391
STAYEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3	PLE CONSTRUCTION G		ATE SURVEY DMPLETED C
		495371	B. WING _	33. 5		01/28/2019
1999/00/1999/1995/04 8000	ROVIDER OR SUPPLIER HALL-RICH CREEK	Ē		STREET ADDRESS, CITY, STATE, 1 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION EACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 623	gastro-esophageal r scalp, chronic diasto infarction, dysphagia polyneuropathy, and hyperlipidemia. Resident #90's sign minimum data set (l assessment referer assessed the residemental status (BIM: A telephone order or resident to ER (em (evaluation) & treat The surveyor revied dated 10/29/18 10: "Late Entry: This n gym. Resident was Resident stated shout to the floor. Upon she had pain in he head on a pain so head had hemator assisted to wheeld (medical doctor) in concerned of resident wanted resident wanted resident wanted resident left volume to the floor. Departmental not read in part "Resident second physici." May send out to (treatment) due to	eflux disease, contusion of solic heart failure, cerebral a, major depressive disorder, emia, hypertension, and difficant change in assessment MDS) assessment with an accedate (ARD) of 1/2/19 ent with a brief interview for S) as 7/15. Idated 10/29/18 read "May send ergency room) for eval actreatment)." Wed the departmental note 44 p.m. The note read in part: urse was called to therapy so found in floor on right side. We had lost her balance and fell assessment resident stated ar right hip and right side of her ale of 4 out of 10. Right side of ma present. Resident was chair and to her room. MD otified (name omitted) dent on Coumadin with the fall ent to be sent to ER (name rt arrived at 1820 (6:20 p.m.)	F	623		

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 19 of 57

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 8 8	(X2) MULTIPLE CONSTRUCTION A: BUILDING			TE SURVEY MPLETED
	450	495371	B, WING				C 1/28/2019
	ROVIDER OR SUPPLIER E HALL-RICH CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	CARREL .	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 623	dated 11/4/18 6:46 p. entry 6 p.m. Residen confusion with big ch has been very comba Resident can normal conversation, but car doing things to herse hair, bending fingers staff and stating "lool you did this. You are This is not normal be nurse sent to ER for and RP (responsible	en) sat (saturation)." ed the departmental note rn. The note read "Late t noted to have increased ange in personality. She ative to staff this shift.	F	623			
	written notice of trans and the resident reprombudsman notificat clinical record. The surveyor information record for either of Remergency room and the hospital on 10/29 at 3:55 p.m. The directors only information sent	ad no documentation that the ofer was given to the resident essentative and there was no ion documented in the ed the director of nursing of a not found in the clinical esident #90's transfers to the I subsequent admissions to 1/18 and 11/4/18 on 1/27/19 ector of nursing stated the with the resident was the edication administration				p.	
	director of nursing an nurse of the above of	ed the administrator, the did the corporate registered concern during the end of the 119 at 4:14 p.m. The survey	ij 45		zi.		

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495371	U jaki is	(X2) MULTIPLE CONSTRUCTION A. BUILDING		C 1/28/2019
	ROVIDER OR SUPPLIER	8	120 0	ET ADDRESS, CITY, STATE, ZIP CODE DLD VIRGINIA AVENUE CREEK, VA 24147	•	
(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 623	team asked what intresidents are transfedirector of nursing simedication administ DON stated the faction a form called "Incompleted. The suipolicy on transfers/d. The director of nursithe policy titled "Be 1/25/19. The policy and therapeutic lear representatives will bed-hold and return. The director of nurstransfers/discharge on 1/28/19. 3. The facility staff of transfer to the representative and ombudsman notific when Resident #2 hospital. The clinical record reviewed 1/23/19 #218 was admitted readmitted 1/21/1 but not limited to cellulitis of right to failure with hyper Resident #218's a (MDS) assessmenterence date (Assert Resident Reside	formation was provided when erred to the hospital. The tated the face sheet and the tration record (MAR). The lity was just beginning to work teract" but had to be reveyor requested the facility discharges. Sing provided the surveyor with d-Holds and Returns" on y read in part "Prior to transfers exes, residents or resident to be informed in writing of the in policy." Ising did not provide a policy for es prior to the exit conference of failed to provide written notice esident and resident to document cation in the clinical record 18 was transferred to the did for Resident #218 was through 1/28/19. Resident did to the facility 4/6/18 and 9 with diagnoses that included acute osteomyelitis, sepsis, ower limb and chronic respiratory	F 623			

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 21 of 57

CENTERS FOR MEDICARE & MEDICARD SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED		
		495371	B. WNG		C 01/28/20	40
	ROVIDER OR SUPPLIER E HALL-RICH CREEK		120	EET ADDRESS, CITY, STATE, ZIP CODE OLD VIRGINIA AVENUE H CREEK, VA 24147	1 01/26/20	i i i
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE COM	(X5) PLETION DATE
F 623	room visits with tw Resident #218 wa- on 11/24/18 for ab There was docum- called to the emen- evidence of what i receiving provider, documentation that was given to the re representative on	revealed three emergency or requiring hospitalizations. It is sent to the emergency room dominal pain and constipation. It is entation that a report was gency room but no further information was provided to the The clinical record had no it the written notice of transfer resident and the resident 11/24/18 and there was no cation documented in the	F 623			d
77	admitted to the ho the physician disci 1/4/19-1/7/19. The 1/4/19 at 3:43 a.m wheelchair with so appointment. No The departmental read "Resident co The departmental read "Resident rer hospital."	revealed Resident #218 was spital 1/4/19 as evidenced by harge summary for e departmental note dated read "Resident left facility via on at 3:40 a.m. to go to an skin issues or distress noted." note dated 1/4/19 at 11:44 a.m. ntinues to be out of facility." note dated 1/4/19 at 10:44 p.m. mains OOF (out of facility) at				
	written notice of tr and the resident re there was no omb documented in the The clinical record admitted to the ho kidney injury. The	I had no documentation that the ansfer was given to the resident epresentative on 1/4/19 and udsman notification e clinical record. I revealed Resident #218 was spital 1/18/19-1/21/19 for acute edepartmental note dated m, read in part "Resident"		e e		

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING A. BUILDING B. WING NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	DATE SURVEY COMPLETED C C 01/28/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	\$15.59 S
TO INC. OF THE SECTION OF THE SECTIO	51
HERITAGE HALL-RICH CREEK 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	<u> </u>
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
Continued From page 22 complains of feeling bad. Could not state exactly what her complaints were more specifically. Did state she was having double vision and that her vision was wavey. MD (medical doctor-name omitted) notified. Telephone order received to send patient to ER (emergency room) for evaluation and treatment of complaints." The departmental note dated 1/18/19 at 2:24 p.m. read "EMS (emergency medical services) notified for transport to the ED (emergency department), report called to ED (name omitted)." The departmental note dated 1/19/19 at 10:32 a.m. read in part "Resident was admitted 1/18/19 for acute kidney injury." The clinical record had no documentation that the written notice of transfer was given to the resident and the resident representative and there was no ombudsman notification documented in the clinical record. The survey team met with the administrator, the director of nursing (DON), and the corporate registered nurse on 1/24/19 at 4:14 p.m. and informed them of the required information sent to the hospital when a resident was transferred. The DON stated only a face sheet and a medication administration record (MAR) are sent. The DON stated the facility was just beginning to work on a form called "Interact" but had to be completed. The surveyor requested the facility policy on transfers/discharges. The director of nursing provided the surveyor with the policy titled "Bed-Holds and Returns" on 1/25/19. The policy read in part "Prior to transfers	

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 23 of 57

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		200 CO 10 SC 100	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		495371	B. WING			C 1/28/2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147			1/20/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECT!) CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 623	representatives will bed-hold and return process. The director of nursing the director of nursing the second seco	es, residents or resident be informed in writing of the	F	623		
	transfer/discharge in resident representati ombudsman notificat	iled to provide written formation to the resident and we and failed to document tion in the clinical record was sent to the hospital		*		
	1/23/19 through 1/28 admitted to the facilit 7/3/18 with diagnose to acute and chronic hypoxia, hypothyroic major depressive dis bronchitis, repeated	f Resident #25 was reviewed 3/19. Resident #25 was by 2/10/18 and readmitted as that included but not limited respiratory failure with dism, hypercholesterolemia, sorder, hypertension, acute falls, hyperlipidemia, a 2 right buttock, and discitis.		2	9	
	(MDS) assessment vireference date (ARD	terly minimum data set with an assessment o) of 11/21/18 assessed the interview for mental status	=			
	dated 1/11/19 that re (emergency room) (eval (evaluation)/tx (c/o (complaints of) p	evealed a telephone order ead "May send out to ER name of hospital omitted) for (treatment) d/t (due to) fall & pain."			zi .	
		The note read in part:				

PRINTED: 02/06/2019 FORM APPROVED

CENTERS FOR MEDICARE	& MEDICAID SERVICES		OMB NO. 0938-0391		
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495371	B. WNG		01/	28/2019
NAME OF PROVIDER OR SUPPLIER	3 2	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE HALL-RICH CREEK	:		DLD VIRGINIA AVENUE I CREEK, VA 24147		•
PREFIX (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY 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	(X5) COMPLETION DATE
in the floor. Reside on his left side on was coming from forearm. Pressur areas. 911 was contacted that his left hurting. Unable to resident's refusal (responsible part x3 attendants. Resident left the called to ER (em The departments that written notice information was resident represe transferred to the documentation of in the clinical recipients in the 1/24/19 at 4:14 director of nursidents in the registered nurse sent with the residents are cord.	n.) staff stated that resident was dent was observed to be laying the left side of the bed. Blood resident's head and left e was held onto (sic) bleeding alled for transport. Resident thip, left shoulder and head was o do neuro checks due to. MD (medical doctor) and RP y) aware. Rescue squad arrived esident was assisted onto the idants and 2 employees. facility at this time. Report was ergency room) (name omitted)." All note failed to have evidence e of transfer/discharge provided to the resident and intative when Resident #25 was a hospital and there was no formbudsman notification found ford. The discussed the concerns charges and information sent with end of the day meeting on o.m. with the administrator, the ing (DON) and the corporate included and the medication administration mation was provided prior to the	F 623			

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

5. There were six other residents who were transferred to hospitals and the facility staff failed to provide written notice of transfer/discharge to

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 25 of 57

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495371	B. WING	B. WNG		C	
	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 20 OLD VIRGINIA AVENUE RICH CREEK, VA 24147		28/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 623	failed to document or clinical record. Those as Resident #267, Re Resident #115, Resid The survey team met director of nursing (Do registered nurse on 1/2 during the meeting as provided to the receiv transferred to the hose face sheet and the mercord were sent. The does not give the resid representative written transfer/discharge. The was reviewing a form No further information exit conference on 1/2	esident representative and abudsman notification in the residents were identified sident #83, Resident #36, ent #19, and Resident #69. with the administrator, the DN) and the corporate (24/19 at 4:14 p.m. and ked what information was ing provider when pital. The DON stated the edication administration a DON stated the facility dent and resident notice of the DON stated the facility called Interact for transfers.		623			
F 625 SS=C	CFR(s): 483.15(d)(1)(§483.15(d) Notice of the §483.15(d)(1) Notice the resident goes on the resident goes on the resident or resider specifies— (i) The duration of the any, during which the return and resume restacility;	ped-hold policy and return- perfore transfer. Before a ars a resident to a hospital or herapeutic leave, the rovide written information to at representative that state bed-hold policy, if resident is permitted to sidence in the nursing	F		Corrective Action(s): Residents #104, #90, #218, #83, #36, #115,#69 and them RP's have been notified of facilities bed-hold policy procedure and the requirementation that it reviewed and issues writing to the resident and RP when discharge to the hospital or when going out the the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the appearance of the hospital or when going out the hospital or when going out the appearance of the hospital or when going out the hospital or when going or when going out the hospital or when going or when going or when going out the hospital or when going or when g	ir the and ent d in d the on ident	

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION		A. BU!LDING	3 <u></u>	(X3) DATE SURVEY COMPLETED	
DOT .	495371	B. WING		01/28/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK		8	STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLET	
paragraph (e)(1) of the resident to return; and (iv) The information is of this section. §483.15(d)(2) Bed-hot the time of transfer of hospitalization or their facility must provide the resident representative specifies the duration described in paragral. This REQUIREMENT by: Based on staff intervant clinical record reto provide to the resident representative at the written notice which bed-hold policy for 8 #104, Resident #83, Resident #115, Resident #69). The findings includes 1. The facility staff fill #104 and the reside information about be was transferred to the trans	y's policies regarding ch must be consistent with is section, permitting a dispecified in paragraph (e)(1) old notice upon transfer. At f a resident for rapeutic leave, a nursing to the resident and the everywhelm of the bed-hold policy ph (d)(1) of this section. T is not met as evidenced eview, facility document review eview, the facility staff failed dent and the resident time of transfer/discharge specifies the duration of the of 29 residents (Resident #36, dent #218, Resident #25 and	F6	Identification of Deficie Practice(s) and Corrective Action(s): All other residents could potentially be affected. Bed-Hold policy and forms now kept at the nursing stor after hour's transfer the hospital to be complete the charge nurse. The Sc Services director/Admissi director will be responsifor normal business hour fer notification of all holds to residents and/or Responsible parties. Systemic Change(s): The facility Policy and Procedure has been revie and no changes are warrathis time. The Social S Director, Admissions Director, Admissions Director, Admissions Director, and the proper use and no changes are warrathis time. The Social S Director, and the Bed-Hold requirement and the proper use and no cation of the Bed-Hold publication of the Bed-Hold publication.	The are station as to sted by scial sons ble trans-sed- wed nted at ervices ector been strator ent solicy. and are sce. from lited	

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 27 of 57

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495371	B. WING			3	
NAME OF D	ROVIDER OR SUPPLIER	430311	D. TWING			01/	28/2019
	HERITAGE HALL-RICH CREEK			12	TREET ADDRESS, CITY, STATE, ZIP CODE O OLD VIRGINIA AVENUE ICH CREEK, VA 24147		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	restlessness and agit femur fracture, metab tract infection, and hy Resident #104's signi set (MDS) assessmer reference date (ARD) resident with a brief in (BIMS) as 4/15. The departmental not p.m. read in part "She time for direct admit to omitted). Transported service omitted) and the time for direct admit to omitted). The 12/19/1 note read, "RGH (named wanted to know with the departmental not 1/24/19. The 12/19/1 note read, "RGH (named wanted to know with the direct of have a bed at (sic) at this time." The clinical record have bed hold was offered resident representative hospital on 12/19/18. The surveyor informed director of nursing and nurse of the above conday meeting on 1/24/1 team asked what inforesidents are transfer director of nursing started the nurse of the	ation, insomnia, infected left folic encephalopathy, urinary pertension. ficant change minimum data at with an assessment of 1/9/19 assessed the aterview for mental status e dated 12/19/18 at 2:18 as is leaving facility at this or RGH (name of hospital divia (name of ambulance two attendants."	F		and/or Admissions Directorensure proper bed-hold not fication was completed at time of transfer or there leave. Any/all negative findings will be corrected time of discovery. The roof these audits will be fiverded to the Quality Ass Committee quarterly for ranalysis, and recommendate for change in facility poprocedure, and/or practice Completion Date: 3/12/	ti- the peutic d at esults or- urance eview, ions licy, ee.	

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CON		(X3) DATE SURVEY COMPLETED	
		495371	B. WING		01/28/2019
	ROVIDER OR SUPPLIER E HALL-RICH CREEK		120 0	ET ADDRESS, CITY, STATE, ZIP CODE DLD VIRGINIA AVENUE I CREEK, VA 24147	E .
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFTX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 625	was asked if this inf documented in the stated the nurses sholds are offered in. The director of nurse the policy titled "Be 1/25/19. The policy and therapeutic lear representatives will bed-hold and return. No further informate exit conference on. 2. The facility staff and the resident reinformation when the hospital on 10/10. The clinical record 1/23/19 through 1/12 admitted to the fact 11/2/18 and 11/7/15 but not limited to when behavioral disturb hypothyroidism, clintertrochanteric fingastro-esophages scalp, chronic dialinfarction, dysphapolyneuropathy, a hyperlipidemia. Resident #90's siminimum data se assessment reference of nurse states assessment reference in the states of the sta	ormation should be clinical record. The DON hould document when bed the clinical record. In part "Prior to transfers ves, residents or resident be informed in writing of the policy." In was provided prior to the 1/28/19. If alled to provide Resident #90 presentative written bed hold he resident was transferred to 29/18 and 11/4/18. If Resident #90 was reviewed 28/19. Resident #90 was cility 3/13/17 and readmitted ascular dementia without ances, type 2 diabetes mellitus, ervical disc disorder, right femuracture, osteoporosis, al reflux disease, contusion of stolic heart failure, cerebral gia, major depressive disorder, memia, hypertension, and gnificant change in assessment to (MDS) assessment with an ence date (ARD) of 1/2/19 ident with a brief interview for	F 625		

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 29 of 57

STATÉMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495371 B. WING				С		
		495371	B. WING _			01/:	28/2019
NAME OF PI			120	REET ADDRESS, CITY, STATE, ZIP CODE O OLD VIRGINIA AVENUE CH CREEK, VA 24147		(4)	
(X4) ID PREFIX TAG	SUMMARY ST, (EACH DEFICIENC REGULATORY OR I	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD			(X5) COMPLETION DATE	
F 625	resident to ER (emerg	ted 10/29/18 read "May send gency room) for eval	F6	525	per Si		
	dated 10/29/18 10:44 "Late Entry: This nurs gym. Resident was fi Resident stated she h to the floor. Upon as: she had pain in her ri head on a pain scale head had hematoma assisted to wheelchai (medical doctor) notif concerned of resident and wanted resident omitted). Transport as and resident left via s	d the departmental note p.m. The note read in part: se was called to therapy bund in floor on right side. and lost her balance and fell sessment resident stated ght hip and right side of her of 4 out of 10. Right side of present. Resident was in and to her room. MD led (name omitted) to no Coumadin with the fall to be sent to ER (name mived at 1820 (6:20 p.m.) tretcher."	G.				
	read in part "Residen A second physician o "May send out to ER (treatment) due to inc combativeness, trying decreased O2 (oxyge The surveyor reviewed dated 11/4/18 6:46 p. entry 6p.m. Resident confusion with big ch has been very combat Resident can normall conversation, but car doing things to herse	en) sat (saturation)." ed the departmental note m. The note read "Late noted to have increased ange in personality. She tive to staff this shift.					

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Calculation solutions acreation	(X2) MULTIPLE CONSTRUCTION (A. BUILDING		(X3) DATE SI COMPLE	
		405074	D MANG				
NAME OF P	ROVIDER OR SUPPLIER	495371	B. WING	B. WINGSTREET ADDRESS, CITY, STATE, ZIP CODE			8/2019
HERITAGE HALL-RICH CREEK			•		120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 625	staff and stating "look you did this. You are This is not normal be nurse sent to ER for and RP (responsible nurses decision and hospital." The clinical record d that written notice of provided to the resid representative when transferred to the horomore the above information record for either of F emergency room and the hospital on 10/2 at 3.55 p.m. The did only information ser face sheet and the record (MAR). The surveyor inform director of nursing a nurse of the above day meeting on 1/2 team asked what in residents are transf director of nursing serice and the nurse of the above day meeting on 1/2 team asked what in residents are transf director of nursing serice and the nurse of the above day meeting on 1/2 team asked what in residents are transf director of nursing serice and the nurse of the above day meeting on 1/2 team asked what in residents are transf director of nursing serice and the nurse of the above day meeting on 1/2 team asked what in residents are transf director of nursing serice and the nurse of the nurse of the nurse of the nurse of the above day meeting on 1/2 team asked what in residents are transf director of nursing serice and the nurse of the	k here, I'm going to tell them e going to be accused of it." ehavior for this resident. This eval and tx. Physician aware party) agrees with this is meeting resident at id not have documentation bed hold information was lent and the resident	E.	625			

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 31 of 57

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495371 B. WING					C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	CODE	01/28/2019
(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 CEACH CORRECTIVE ACCURATE CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIA	
F 625	The director of nursing the policy titled "Bed-1/25/19. The policy of and therapeutic leaves representatives will be bed-hold and return of the policy of and therapeutic leaves representatives will be bed-hold and return of the policy of th	ng provided the surveyor with al-Holds and Returns" on read in part "Prior to transfers es, residents or resident e informed in writing of the policy." In was provided prior to the 28/19. Alied to provide Resident at representative written dehold when the resident e hospital 11/24/18, 1/4/19, Resident #218 was pugh 1/28/19. Resident to the facility 4/6/18 and ith diagnoses that included the osteomyelitis, sepsis, a limb and chronic respiratory mia.	F6	525		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CON		(X3) DATE SURVEY COMPLETED		
	and the same of th		A. BUILDING			С	
		495371	B. WING	Maria Maria	0.	1/28/2019	
	ROVIDER OR SUPPLIER		120 C	T ADDRESS, CITY, STATE, ZIP CODE	SC 36		
			RICH	CREEK, VA 24147	on and the same	1800 80000	
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 625	when transferred. The clinical record in admitted to the hosp the physician discharman	evealed Resident #218 was oital 1/4/19 as evidenced by	F 625		и		
	read "Resident cont The departmental read "Resident rem hospital." None of the notes of sent to the receiving did not return to the information about the	tinues to be out of facility." note dated 1/4/19 at 10:44 p.m. ains OOF (out of facility) at dated 1/4/19 detail information g provider when the resident a facility on 1/4/19 or need holds was offered to the					
e .	surveyor interviewe 3:37 p.m. The resi was informed abou			e.			
	admitted to the hos kidney injury. The 1/18/19 at 1:53 p.r complains of feelin what her complain state she was hav vision was wavey. omitted) notified, send patient to EF evaluation and tre	revealed Resident #218 was spital 1/18/19-1/21/19 for acute departmental note dated in read in part "Resident ing bad. Could not state exactly its were more specifically. Did ing double vision and that her MD (medical doctor-name Telephone order received to R (emergency room) for atment of complaints."					
	read "EMS (emer	note dated 1/18/19 at 2:24 p.m. gency medical services) notified a ED (emergency department),					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		•	(X3) DATE SURVEY COMPLETED		
		495371	B. WNG		1302		9	C
NAME OF PROVIDER OR SUPPL			120 (ET ADDRESS, CITY, STATE, ZIP CODE DLD VIRGINIA AVENUE I CREEK, VA 24147		<u> </u>	/28/2019	
PREFIX (EACH DE	FICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
a.m. read in particular for acute kidne. The surveyor win the clinical reinformed the adand the corporaconcern during 1/24/19 at 4:14 information was transferred to the stated the face administration the nurses usuresidents are truthis information clinical record. Should docume the clinical record. Should docume the clinical record. The director of the policy titled 1/25/19. The pland therapeutic representatives bed-hold and rewitted the facility stand the resider information aboves transferred.	ED (notal notal no	e dated 1/19/19 at 10:32 ident was admitted 1/18/19 ident above do for the director of nursing and the director of nursing and the medication (MAR). The DON stated for a bed hold when the red. The DON was asked if did be documented in the ON stated the nurses in bed holds are offered in the dolds and Returns" on the red in part "Prior to transfers is, residents or resident informed in writing of the olicy." was provided prior to the	F	525				

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED C		
		495371	B. WING _		O·	1/28/2019	
	ROVIDER OR SUPPLIER E HALL-RICH CREEK			STREET ADDRESS, CITY, STATE, ZIP COL 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147)E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 625	admitted to the facil 7/3/18 with diagnosto acute and chronic hypoxia, hypothyroi major depressive dibronchitis, repeated pressure ulcer stag Resident #25's qua (MDS) assessment reference date (AR resident with a brie (BIMS) as 15/15. The clinical record dated 1/11/19 that (emergency room) eval (evaluation)/b c/o (complaints of) The surveyor revied departmental note "@1728 (5:28 p.m in the floor. Resid on his left side on was coming from forearm. Pressure areas. 911 was castated that his left hurting. Unable to resident's refusal. (responsible party x3 attendants. Resident left the facilled to ER (emergency remains the floor in the	8/19. Resident #25 was ity 2/10/18 and readmitted es that included but not limited a respiratory failure with dism, hypercholesterolemia, sorder, hypertension, acute I falls, hyperlipidemia, e 2 right buttock, and discitis. Interly minimum data set with an assessment D) of 11/21/18 assessed the finterview for mental status revealed a telephone order read "May send out to ER (name of hospital omitted) for a (treatment) d/t (due to) fall &	F	625			

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

Event ID; C2YF11

Facility ID: VA0206

If continuation sheet Page 35 of 57

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ 495371 B. WNG 01/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE HERITAGE HALL-RICH CREEK RICH CREEK, VA 24147 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 625 Continued From page 35 F 625 information that Resident #25 bed hold information was offered to the resident and the resident representative. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern during the end of the day meeting on 1/24/19 at 4:14 p.m. The survey team asked what information was provided when residents are transferred to the hospital. The director of nursing stated the face sheet and the medication administration record (MAR). The DON stated the nurses usually offer a bed hold when the residents are transferred. The DON was asked if this information should be documented in the clinical record. The DON stated the nurses should document when bed holds are offered in the clinical record. No further information was provided prior to the exit conference on 1/28/19. 5. There were four other residents who were transferred to hospitals and the facility staff failed to provide written bed hold information to the resident and the resident representative. Those residents were identified as Resident #83. Resident #36, Resident #115, and Resident #69, The survey team met with the administrator, the director of nursing (DON) and the corporate registered nurse on 1/24/19 at 4:14 p.m. and during the meeting asked what information was provided to the receiving provider when transferred to the hospital. The DON stated the face sheet and the medication administration record were sent. The DON stated the nurses

usually offer a bed hold when the residents are transferred. The DON was asked if this

PRINTED: 02/06/2019

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(800) 30		ONSTRUCTION	(X3) DATE SU COMPLE	
THE LONG OF		ee59 207505 55, 74	****			С	i i
		495371	B. WING_			01/28	3/2019
	OVIDER OR SUPPLIER			120	REET ADDRESS, CITY, STATE, ZIP CODE OLD VIRGINIA AVENUE CH CREEK, VA 24147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	0.000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE I	(X5) COMPLETION DATE
F 625	record. The DON st document when bed clinical record. The director of nursi the policy titled "Bed 1/25/19. The policy and therapeutic leav representatives will bed-hold and return	e documented in the clinical ated the nurses should holds are offered in the ng provided the surveyor with Holds and Returns" on read in part "Prior to transfers yes, residents or resident be informed in writing of the policy."	F	625			
	Free of Accident HacCFR(s): 483.25(d)(1) §483.25(d) Accident The facility must en §483.25(d)(1) The as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on, clinical observation, reside document review, a hazard free envir Resident #36. The findings included The facility staff fa environment while	exards/Supervision/Devices (1)(2) ets. sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced record review, staff interview, ent interview, and facility the facility staff failed to ensure ronment for 1 of 29 residents,	F	689	Corrective Action(s): Resident #36's attending physician has been notification that facility staff fails maintain a hazard free and during a resident transfer which resulted in a skin to the lower leg. A facilincident and accident for been completed for this incident. Identification of Deficient Practices/Corrective Activation assistance with transfers the wheelchair may have be potentially affected. The ADON, Therapist and/or Undanager will conduct a 1 review of all residents status to identify residents.	ed to rea er tear ility m has ent ion(s): iring s from been he DON, nit 00% transfe	

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 37 of 57

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Contract to the contract to th	LE CONSTRUCTION	1 31 51	SURVEY PLETED
		405074				С
NAME OF C	DOMEDED OD DIAGOLIES	495371	B. WNG			28/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	E	*
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 689	lower leg during a trathe bed. Resident #36 was at 10/28/18. Diagnoses limited to, fracture of left foot, Alzheimer's communication deficient unsteadiness on fee fibrillation. Section C (cognitive most recent compresset) assessment with reference date) of 11 (brief interview for mof 10 out of a possib (functional status) has extensive assistance assist (3/3) for transformation: Resident #36's compute focus area: "ADL Function: Resident more daily ADL care included but were not Resident to participate to bed and she did so blood run out. It's better the surveyor spoke on 01/24/19 10:39 at Resident #36 acquire transferred to the bed	dimitted to the facility on sincluded, but were not funspecified tarsal bone of disease, cognitive it, hypertension, t, depression, and atrial patterns) of Resident #36's mensive MDS (minimum data in an ARD (assessment /25/18 included a BIMS ental status) summary score led 15 points. Section G and been coded to indicate with two persons physical fer. The prehensive care plan included a (activities of daily living) equires assistance from staff in the limited to, "Encourage the in ADL care as tolerated". The weed Resident #36 on esident #36 stated "The CNA distant) was trying to put me omething that made the en there for a month".	F 68		echniques All dat risk r the r techni- dents me of dis- ent & be com- ative and ent and manage- wed and no nted at and/or ultant will ng staff techniques and/or leg rests to trans- ury. ble for mager will ls through- tor for from the	

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	0 0		CONSTRUCTION	(X3) DATE S	
DATOF			A. BUILDIN	<u> </u>		1 0	
		495371	B. WING				!8/2019
NAME OF DE	OURDED OF CHIRD SER	455071		STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 01/2	.0/2013
NAME OF PE	ROVIDER OR SUPPLIER				0 OLD VIRGINIA AVENUE		
HERITAGE	HALL-RICH CREEK				CH CREEK, VA 24147		
					PROVIDER'S PLAN OF CORRECTION	i I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 689	Continued From pag	e 38	F6	389	compliance. Any/all neg	ativo	
	off her wheel chair n				findings will be correct	THE PERSON AND THE PE	
						A CONTRACTOR OF THE CONTRACTOR	
	On 01/25/19 at 11:35	5am, the surveyor interviewed			time of discovery and di	8.00	
		CNA #1 stated, "Resident			linary action will be ta		
	#36's wheelchair wa	s locked. Resident #36 was		1	needed. Aggregate findi	CONTRACTOR INVESTIGATION	
		and I was using the gait belt		954	these reviews will be re		
		#36 is a one person assist			to the Quality Assurance	i i	
		Resident #36 was standing			Committee quarterly for		
8	with the back of her				review, analysis, and re		
		nt #36's blanket was wrapped			dations for change in fa		
		heelchair. She started nair to loosen the blanket.		ļ	policy, procedure, and/o	r	1
	The state of the second section of the second section is the second section of the second section sect	ame loose the leg rest swung		j	practice.		
	The second second	#36 in the left leg causing a					
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	voiced that she sat Resident		1	Completion Date: 3/12/	19	
Į,		provided pressure to the					
1	wound with a clean	towel. CNA #1 called the					
ľ	nurse to evaluate R	esident #36 and provide	Ì	7			
	1	stated "I forgot to take the leg		100			
		chair, but I didn't realize it	1				
1		vas standing to be transferred.					
		e her standing unsupported or	į				Į.
-		e floor as that could be a					8
		CNA #1 voiced that she tesident #36 without any issue.					
	The surveyor review	wed a facility document titled					
	"Resident Incident	Report", under the section					
Ì	- Contractions - Contractification and Contraction - Contraction	ess Statement" read in part: "I				92	
[dent into the bed when the			х.		
		ner bed and blanket. Resident					
2		er chair while I was holding her					
e e		ad gotten free. That's when the					
Į.		air came around and knocked					
	conversional description and an arrangement of the second description and t	ent belted out a loud scream d her leg she had blood					
1		r leg had a deep skin tear. So I					
		I held a rag around the wound					
	1	ed" The foretold statement was					

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 39 of 57

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING_ C 495371 B. WING 01/28/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE HERITAGE HALL-RICH CREEK RICH CREEK, VA 24147 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 689 Continued From page 39 F 689 signed by CNA #1 and dated 12/15/18. The surveyor reviewed Resident #36's clinical record on 01/28/19 at 10:49am. A nursing note dated 12/15/18 at 10:14pm documented by LPN (licensed practical nurse) #1 read in part: "7:20 pm called to Resident's room. CNA was assisting Resident to bed. Her leg got caught on wheelchair. Place on left leg about 4 inches long and at one point an inch wide, 1/4 inch deep. Bleeding from area. Pressure applied to stop bleeding. Steri-strips used to pull area together and triple antibiotic ointment applied. 4x4 applied and wrapped. Resting in bed. Took pain pill and all meds without difficulty ... Doctor and responsible party (son) notified. Call light in reach". LPN #1 documented a nursing note dated 12/21/18 at 4:30pm that read in part: "New order from doctor received to send Resident to ER (emergency room) for evaluation of wound ...". ED (emergency department) summary dated 12/21/18 read in part under diagnoses: "Skin tear to left lower leg without complication" under instructions of ED Summary it read in part: "... skin tear though painful does not appear infected....All labs fine...x-ray shows no deep infection...". RN #2 documented a nursing note dated 12/22/18 at 1:13am that read in part: "Resident returned back to facility ... Orders received from doctor to start Norco 5/325 every 8 hours as needed ... He also wants facility's wound care nurse to follow up on wound care ..."

The administrative team was made aware of the

PRINTED: 02/06/2019

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second control of the second	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495371	B. WING		C 01/28/2019
	ROVIDER OR SUPPLIER HALL-RICH CREEK		1	TREET ADDRESS, CITY, STATE, ZIP CODE 20 OLD VIRGINIA AVENUE NICH CREEK, VA 24147	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 689	above findings on 0	1/25/19 at 1:57pm.	F 689		
1,400 466,600,000	conference on 01/2: Bowel/Bladder Inco CFR(s): 483.25(e)(*) §483.25(e) (1) The f resident who is con admission receives maintain continence condition is or beco not possible to main §483.25(e)(2)For a incontinence, base	ntinence, Catheter, UTI I)-(3) ence. acility must ensure that tinent of bladder and bowel on services and assistance to e unless his or her clinical mes such that continence is ntain. resident with urinary	F 690	Corrective Action(s): Resident #104, #34 and # Foley catheters are now anchored per policy and cedure to reduce friction pulling and movement to injury. The resident's plan has been revised to flect accurate Foley cate care to include proper punent and anchoring of the catheter.	pro- on, prevent care o re- theter olace-
	ensure that- (i) A resident who e indwelling catheter resident's clinical co catheterization was (ii) A resident who indwelling catheter is assessed for rem as possible unless demonstrates that and (iii) A resident who receives appropria prevent urinary trac continence to the e	enters the facility without an is not catheterized unless the condition demonstrates that a necessary; enters the facility with an or subsequently receives one noval of the catheter as soon the resident's clinical condition catheterization is necessary; is incontinent of bladder te treatment and services to cot infections and to restore extent possible.		Identification of Defici Practice(s) and Corrects Action(s): All other residents with catheter may have been p ially affected. The DOM and or Unit Manager will duct a 100% review of all residents with a Foley of to identify residents at Residents identified will corrected at time of dis and a Facility Incident Accident Form will be considered.	ive n a Foley cotent- N,ADON l con- il catheter t risk. ll be scovery &
1	comprehensive as	sessment, the facility must		The facility Policy and	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
						с
		495371	B. WNG		01/	28/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0 00 00 00	
HERITAGI	E HALL-RICH CREEK			120 OLD VIRGINIA AVENUE		Ì
i i E i u i zi o	TIMEE-MOIT OREEM			RICH CREEK, VA 24147		
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 690	ensure that a resident receives appropriate to restore as much norm possible. This REQUIREMENT by: Based on observation document review and facility staff failed to put reatment and services a clinically justified inclinidwelling Foley cathed 3 of 29 residents (Resident #69). The findings included 1. The facility staff fare #104's indwelling Foley cathed 1/2 individual for the clinical record of reviewed 1/23/19 through the clinical record of reviewed 1/23/19 with but not limited to hypothemical disturbance restlessness and agit femur fracture, metablication, and hy Resident #104's significant with a brief in (BIMS) as 4/15. Sections was coded for an individual control of the clinical resident with a brief in (BIMS) as 4/15. Sections as a coded for an individual control of the clinical resident with a brief in (BIMS) as 4/15. Sections as a coded for an individual control of the clinical resident with a brief in (BIMS) as 4/15. Sections as a coded for an individual control of the clinical resident with a brief in (BIMS) as 4/15. Sections as a coded for an individual control of the clinical resident with a brief in (BIMS) as 4/15. Sections as a coded for an individual control of the clinical resident with a brief in (BIMS) as 4/15. Sections as a coded for an individual control of the clinical resident with a brief in (BIMS) as 4/15.	t who is incontinent of bowel treatment and services to hal bowel function as it is not met as evidenced and staff interview, facility clinical record review, the provide appropriate as for care of a resident with dwelling catheter when the elers were not anchored for sident #104, Resident #34, it is it i	F 69		ter Care no at this aff will DON on the for care to choring of and he drain- fection ng is aining and/or he daily Foley compli- f tubing of tor tive rected at betailed t will be ty for change procedure,	
	And the second s	catheter (indwelling, omy, or no urine output for				

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER: 495371	(X2) MULTIPLE CON A. BUILDING		CON	E SURVEY IPLETED C 1/28/2019
	IAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK		STREE	ET ADDRESS, CITY, STATE, ZIP CODE DLD VIRGINIA AVENUE CREEK, VA 24147	1	1/20/20 13
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 690	entire 7 days. Current comprehen 1/10/19 identified u catheter. Resident tract infections) r/t (Approaches: chan and as needed (prourine.) The January 2019 16 F (16 French) Fmonth)." The surveyor observed to the bed frame, attended to by lice #1 asked if indwell anchored. L.P.N. # to be." When L.P. anchorage, the Fo #1 stated she would be surveyor observed to the surveyor observed to the bed frame, attended to by lice #1 asked if indwell anchored. L.P.N. # to be." When L.P. anchorage, the Fo #1 stated she would be surveyor observed to the bed frame.	sive care plan initiated rinary incontinency/Foley is at risk for UTIs (urinary (related to) Foley placement. ge Foley catheter every month n), monitor for changes in physician orders read "Change foley catheter month (every eved Resident #104 on 1/23/19 dent #104 was in bed. The la Foley drainage bag attached Resident #104 was being insed practical nurse #1. L.P.N. (ling Foley catheters were #1 stated, "They are supposed N. #1 checked the Foley for foley was not anchored. L.P.N.	F 690			

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 43 of 57

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		NTE SURVEY
		495371	B. WING_			C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147		01/28/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES IY 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 APPROPRIATE	(X5) COMPLETION DATE
F 690	policy on Foley cathe the day meeting on a surveyor asked the E staff to anchor indwe DON stated she would Foleys. The surveyor review "Catheter Care, Uring read in part "2. Ensu secured with a leg st movement at the insus should be strapped to the facility staff farms and the strapped to the clinical record of 1/23/19 through 1/28 admitted to the facility included but not limit hyperglycemia, chrodiastolic heart failure hypothyroidism, aner benign prostatic hypomassessment with a BIMS status) as 13/15. See was coded for an including continence (Krated"-resident had a status) as 13/15. See was coded for an including continence (Krated"-resident had a status) as 13/15. See was coded for an including continence (Krated"-resident had a status) as 13/15. See was coded for an including continence (Krated"-resident had a status) as 13/15. See was coded for an including continence (Krated"-resident had a status) as 13/15. See was coded for an including the continence (Krated"-resident had a status) as 13/15. See was coded for an including the continence (Krated"-resident had a status) as 13/15. See was coded for an including the continence (Krated"-resident had a status) as 13/15. See was coded for an including the continence (Krated"-resident had a status) as 13/15.	and requested the facility eter care during the end of 1/24/19 at 4:14 p.m. The DON if she would expect the Illing Foley catheters. The Id expect staff to anchor ed the facility policy titled eary" on 1/25/19. The policy re that the catheters remains rap to reduce friction and ertion site. (Catheter tubing to the resident's inner thigh.) In was provided prior to the 1/28/19. Alled to anchor Resident by catheter. The Resident #34 was reviewed 1/19. Resident #34 was reviewed 1/19. Resident #34 was that ed to multiple rib fractures, nic kidney disease, chronic purine retention, mia, hypertension, and entrophy. The resident was the entropy of the resident was reviewed 1/19. Resident #34 was re	F6			

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-	0391
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONS		(X3) DATE SURVEY COMPLETED	
		495371	B. WING_			01/28/2019	9
	ROVIDER OR SUPPLIER HALL-RICH CREEK			120 OL	ADDRESS, CITY, STATE, ZIP CODE D VIRGINIA AVENUE CREEK, VA 24147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFU TAG	×	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPL	ETION
F 690	entire 7 days. The January 2019 p 18 F (French) Foley	ge 44 physician orders read "Change catheter q month (every did not contain the bulb size	F	690			
1	of the Foley cathete The surveyor interv 1/24/19 at 9:58 a.m the staff used a str. leg. The resident s strapped. Certified attending to the res asked to check for Foleys were suppo checked, C.N. A. # anchored but "they The surveyor inforr director of nursing, nurse in the end of 4:14 p.m. The sur would expect the s catheters. The DC	iewed Resident #34 on . The resident was asked if ap to hold the catheter to the tated he didn't think it was nursing assistant #1 was sident's roommate and was anchorage. C.N.A. #1 stated sed to be anchored. When 1 stated the catheter was not 're supposed to be." med the administrator, the and the corporate registered if the day meeting on 1/24/19 at veyor asked the DON if she staff to anchor indwelling Foley DN stated she would expect					
9	"Catheter Care, Uread in part "2. En secured with a leg movement at the ishould be strapped." No further information exit conference of the strapped. 3. For Resident #	ewed the facility policy titled rinary" on 1/25/19. The policy issure that the catheters remains a strap to reduce friction and insertion site. (Catheter tubing and to the resident's inner thigh.)					

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 45 of 57

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Communication of the communica		NSTRUCTION		TE SURVEY MPLETED
							С
		495371	B. WING			0	1/28/2019
	ROVIDER OR SUPPLIER E HALL-RICH CREEK			120 C	ET ADDRESS, CITY, STATE, ZIP CODE DLD VIRGINIA AVENUE CREEK, VA 24147	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	200	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 690	Resident #69 was ac 12/03/18. Diagnoses chronic diastolic (corchronic obstructive p chronic respiratory far The most recent MD an ARD (assessment coded the Resident cognitive patterns. Resident #69's CCP was reviewed and combined the combined to the combined that were not catheter care every substituted but were not catheter care every substituted to 1/28/18. It containes to summary which react catheter care every substituted that the combined that the catheter was and observed the catheter was positioned across. The concern of the Fanchored was discusted the catheter that the concern of the Fanchored was discusted the catheter that the concern of the Fanchored was discusted the catheter that the concern of the Fanchored was discusted the catheter that the concern of the Fanchored was discusted the catheter that the concern of the Fanchored was discusted the catheter that the concern of the Fanchored was discusted the catheter that t	Imitted to the facility on included but not limited to include but not limited to include include included but not limited. S (minimum data set) with the treference date) of 12/10/18 included inclu	F	690			

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE &	MEDICAID SERVICES				CIVID NO.	0930-0391
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		ONSTRUCTION	(X3) DATE S COMPLI	
		1				C	1
		495371	B. WNG_	10		01/2	8/2019
NAME OF PE	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
UEDITACE	HALL BIOLICBEEK			120	OLD VIRGINIA AVENUE		1
RENIAGE	HALL-RICH CREEK			RIC	CH CREEK, VA 24147	550	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFU TAG	·	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	Continued From pag	ge 46	F	590			l i
	PRESERVATION OF TRACES SEE SE	ninistrator provided the					
		olicy titled "Catheter Care,		ļ			
		9. This policy read in part		Ì		1	
	under sectioned title	d "Steps in the Procedure"18.					A CO
	Secure catheter utili	zing a leg band".					
	, p	F 5		ļ			B
F 00F		on was provided prior to exit.	-	205	Corrective Action(s):		
		ostomy Care and Suctioning	F	695	Resident #37's attending	Y	
SS=D	CFR(s): 483.25(i)				physician was notified	- 10	9
	§ 483.25(i) Respirat	tory care including			resident #37 did not rec	5 39);
		and tracheal suctioning.			oxygen at the correct fi		
		sure that a resident who			rate as ordered by the		
a.		are, including tracheostomy	# E		cian. A facility Incide		
		uctioning, is provided such			Accident form has been of		
e E	- Balling and the control of the con	h professional standards of			ed for this incident.		
		ehensive person-centered	ř				
	and 483.65 of this	ents' goals and preferences,			Resident #25's attending	3	
		NT is not met as evidenced			physician was notified		
ľ	by:	The moral of the original of t			resident #25 did not red		
	A CONTRACTOR OF THE PERSON NAMED IN	tion, staff interview, facility			oxygen at the correct fi	low	
Į		and clinical record review, the			rate as ordered by the		
		provide respiratory care and			ian and the oxygen tubin	ng was	
		ance with professional			noted with no date to in		
	The contraction of the contracti	the resident's care plan and ce for 3 of 29 residents			it was changed weekly as		
	The second secon	sident #108, and Resident			ordered. A facility Inc		
	#25).	sident #100, and resident			Accident form has been	comple-	1
]	,				ted for this incident.		
	The findings includ	led:	úi:				
					Resident #108's attending		
		ffailed to ensure the physician			physician was notified		
		nount was delivered to			the facility failed to		
1	1	failed to change the oxygen			resident #108's nebuliz		
	tubing weekly.				mask in a plastic bag w		La contract of the contract of
ł	The clinical record	of Resident #37 was reviewed			in use. A facility Inc.		
	The Chilical record	OF IVESIDELL #OF MAS LENIEMED			Accident form has been for this incident	complete	e¢1.

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 47 of 57

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1882 NVS		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495371	B. WING				0
NAME OF P	ROVIDER OR SUPPLIER		1		TREET ADDRESS, CITY, STATE, ZIP CODE	01/	28/2019
IVAVIL OF F	CONDER OR SOFFLIER						
HERITAGI	HALL-RICH CREEK				20 OLD VIRGINIA AVENUE UCH CREEK, VA 24147		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	QI I		PROVIDER'S PLAN OF CORRECTION	1	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	3356	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	50 No 150	COMPLETION DATE
F 695	Continued From page	e 47	F	595	Identification of Defici Practices & Corrective	ent	
	1/23/19 through 1/28/	19. Resident #37 was	1		Action(s):		1
		/ 8/11/18 and readmitted		8	All residents receiving		
		ncluded but were not limited					
	to fracture of right tibi	a, end stage renal disease,			oxygen and nebulizer ther		
		nal dialysis dependence,			may have potentially been		
		us, chronic obstructive	ļ		affected. A 100% review	80 20 0 100 NOT 101 NOT 100 NOT 100	8
		nemia, hypertension,			residents receiving oxyge		
	hyperlipidemia, chror	Marien - de an metabolica			hebulizers will be conduc	tea by	
	gastro-esophageal re	flux disease.			the DON, ADON and/or Unit		
	Decident #27's sund	adv minimum data aat			Manager to identify resid		
	(MDS) assessment w	erly minimum data set			at risk for not having ox		
		of 1/23/19 assessed the	i		administered per MD order		
		(brief interview for mental		8	improper storage of oxyge		
		ction O Special Treatments,		12	hebulizer equipment when		1
		grams was coded for oxygen			use. Residents found to		ı
	use.	A COLOR OF THE PROPERTY OF THE			risk will be corrected at		Ī
					time of discovery. A fac		
	Resident #37's currer	nt comprehensive care plan			Incident & Accident form	POST OF THE OWNER OF	
	identified respiratory	as a problem with an onset			be completed for each ite	m	
	CONTRACTOR STANDARD CONTRACTOR CO	ident #37 was at risk for	ļ		discovered.		
		ions related to COPD and					1
	and the second of the second o	nt wears O2 at 2 L/M (liters			Systemic Change(s):		1
		es. Approaches: Administer			The facility policy and		
	meds (medications) a (medical doctor) orde	as ordered, O2 per MD		2.	procedure for Oxygen admi		
		er, monitor U2 sats shift (every shift), monitor for	1	- 6	tration has been reviewed		1
	. 2	ions, monitor lung sounds			no changes were warranted		
	qshift, and notify MD	are and the second of the seco			this time. All licensed:		
		,			ing staff will be inservi	ced on	
	The surveyor observe	ed Resident #37 on 1/23/19		20	the facility policy and p	roced-	[
		37 was in bed with oxygen		13 23	re for accurate oxygen a	dmin-	
		3 liters. The oxygen tubing	6		stration and monitoring		
	had a pink sticker that	at was dated 1/12/19.			physician order. Inservi		
		INC SHOW IN AN ACCUMULATION OF		0.7	vill include the delivery		
		ed Resident #37 again on			xygen per physician orde		
		Resident #37 was in bed			nonitoring of oxygen per		
		st. O2 was at 3 liters and			cian order, monitoring o		
<u> </u>	the tubing was dated				oxygen flow rates during		
FORM CMS-256	67(02-99) Previous Versions Ob	salete Event ID: C2YF	11	Fa			t Page 48 of 57

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE S COMPLI	
			A BOILDING		С	
		495371	B. WING	NOTE IN THE PROPERTY OF	01/2	8/2019
	PROVIDER OR SUPPLIER GE HALL-RICH CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	10 No.	
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 69	The surveyor inter #3 what oxygen as #37. L.P.N. #3 st supposed to have the oxygen at 3 lit amount to 2. The surveyor reviphysician's orders 10/9/18 read "O2 (liters per minute) The surveyor information director of nursing nurse of the above day meeting on 1 surveyor request respiratory care. The surveyor reviphesized The surveyor reviphesized The poconsiderations F7. Change the observen (7) days, which was a seven (7) days, which information for the clinical received the amphysician and factors and factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the clinical received to the 7/3/18 with diagonal factors for the control of the clinical received to the 7/3/18 with diagonal factors for the control of the co	rviewed licensed practical nurse mount was ordered for Resident atted Resident #37 was 2 liters. L.P.N. #2 observed ers/nc and changed the liter ewed the December 2018 s. The oxygen order dated via NC (nasal cannula) @ 2L/M continuous." ormed the administrator, the g and the corporate registered re concern during the end of the 1/24/19 at 4:14 p.m. The ed the facility policy on riewed the facility policy on licy read in part "Infection Control Related to Oxygen Administration xygen cannulae and tubing every or as needed."	F 69	and the proper storage oxygen/nebulizer equipment of in uwe. Monitoring: The DON is responsible maintaining compliance DON, ADON and/or Unit will perform daily audiall residents using oxmonitor for compliance negative findings will corrected at time of dand appropriate disciplaction will be taken a All negative findings be reported to the Qualesurance Committee for analysis, and recomment for change in facility procedure, and/or pracedure, and/or pracedure, and/or pracedure.	for The manager its of ygen to All be iscovery linary s needed will lity r review dations policy, ctice.	

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

Event ID: C2YF11

Facility ID: VA0208

If continuation sheet Page 49 of 57

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1000		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495371	B. WING				C
	ROVIDER OR SUPPLIER	45337 1	D. VIIITO	120	REET ADDRESS, CITY, STATE, ZIP CODE OLD VIRGINIA AVENUE CH CREEK, VA 24147	01/	28/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	6/8	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	30	(X5) COMPLETION DATE
F 695	major depressive disciplination of the surveyor observe interest of the surveyor observed in the	sm, hypercholesterolemia, order, hypertension, acute alls, hyperlipidemia, 2 right buttock, and discitis. Perly minimum data set ith an assessment of 11/21/18 assessed the aterview for mental status ction O Special Treatments, grams was coded for oxygen of the comprehensive care plan attified the resident to be at implications related to hx gestive heart failure), neb is daily, wears O2 (oxygen) fluid restriction. Ster meds (medications) per order. Physician's orders read "O2 alla continuous."	F	695			

CENTERS FOR MEDICARE & MEDICAID SERVICES

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY MPLETED	
		495371	B. WING		0	1/28/2019	
	NOVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147				
(X4) ID PREFIX TAG	(EACH DEFICIE	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)	HOULD BE	(X5) COMPLETION DATE	
F 695	Continued From pa	ge 50	F 695				
	breakfast. The oxy	ent #25 was in bed and eating gen concentrator was on 1 ate was observed on the					
20	#3 of the above ob #3 observed the lite moved the concen- asked if the nasal of L.P.N. #3 stated us The surveyor information of the above the day meeting of surveyor requester respiratory care.	ned licensed practical nurse servation at 9:30 a.m. L.P.N er of oxygen setting and crator to 2. L.P.N. #3 was cannula was changed weekly. sually done on 11-7 shift. med the administrator, the and the corporate registered observation during the end of a 1/24/19 at 4:14 p.m. The dithe facility policy on					
	"Respiratory Thera 1/25/19. The polic Considerations Re 7. Change the oxy seven (7) days, or No further informal exit conference or 3. The facility starmask in a plastic to the second	tion was provided prior to the					
	2/22/15 with the for limited to stroke, a On the quarterly M an ARD (Assessm 1/15/19, the resid BIMS (Brief Interview)	ollowing diagnoses of, but not anxiety disorder and depression. MDS (Minimum Data Set) with ment Reference Date) of ent was coded as having a riew for Mental Status) score of the score of 15. Resident #108					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495371	B. WNG		C
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK		s 1	TREET ADDRESS, CITY, STATE, ZIP CODE 20 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	01/28/2019	
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 695	was also coded as re 1 staff member for dri of 1 staff member for dri of 1 staff member for totally dependent on During the initial tour 12:33 pm, the survey nebulizer mask sitting bed. The mask was red. The surveyor went be on 1/24/19 at approxithe surveyor observes stored in a plastic bag. At 4:15 pm on 1/24/19 administrative team of director of nursing states at the survey policy concerning stored in a plastic bag resident." The survey policy concerning stored when not in use. On 1/25/19 at 11 am, copy of the facility's p (Respiratory Therapy The policy read in par plastic bag, marked w name, between uses	quiring limited supervision of essing, extensive assistance personal hygiene and being 1 staff member for bathing. of the facility on 1/23/19 at or observed Resident #108's on the table bedside of the not stored in a plastic bag. ock into the resident's room mately 11 am at which time did the nebulizer mask being 1. O, the surveyor notified the fithe above findings. The ted, "That mask should be a when not in use by the for requested a copy of the rage of a nebulizer mask the surveyor was provided a olicy titled "Departmental of Prevention of Infection. t, "Store the circuit in with date and resident's	F 695		
F 761 SS=D	CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals	d Biologicals	F 761	Corrective Action(s): The 3 bottles of expired artificial tears identification careviews of side 2 medication cart have been removed a	ied rt tion

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	BUILDING				
		graph parameters				C		
-0:-21-21	49	495371	B. WING			01/2	8/2019	
NAME OF PE	ROVIDER OR SUPPLIER	300 V W			TREET ADDRESS, CITY, STATE, ZIP CODE			
UEDITAGO	- NVII - BION CORER			55	20 OLD VIRGINIA AVENUE			
HERITAGE	E HALL-RICH CREEK			R	ICH CREEK, VA 24147			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 761	Continued From page professional principle appropriate accessor instructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In accepted and laws, the fabiologicals in locked temperature control personnel to have a general storage of controlled the Comprehensive Control Act of 1976 abuse, except when package drug distriquentity stored is more readily detected. This REQUIREMED by: Based on observations of a medication of 3 medication.	es, and include the ary and cautionary expiration date when of Drugs and Biologicals cordance with State and cility must store all drugs and dompartments under propers, and permit only authorized access to the keys. Cacility must provide separately affixed compartments for drugs listed in Schedule II of a Drug Abuse Prevention and and other drugs subject to an the facility uses single unit bution systems in which the minimal and a missing dose can service. Note that the service of the service o	7 29500		discarded. All new bottle were obtained and proper dated when opened and put use. A Facility Incident Accident form has been of ted for this incident. Identification of Deficient Practices & Corrective Action(s): All other unit medication rooms, medication carts a medication refrigerators for the storage medication for the storage medication medication medication refrigerators medication refrigerators medication refrigerators medication refrigerators medication refrigerators medication carts to iden any undated, expired or labeled medications, equipor biologicals. Any/all megative findings will be corrected at time of dis A Facility Incident and	Les ly t into t & omple- ent and used ons may fected. t 00% rooms and tify un- ipment e covery. Accider		
	the medication car medications. The	at 11:00 AM, the surveyor checked on cart on Side 2 for expired The surveyor found 3 containers of			Form will be completed fincident identified.			
	containers were la unsampled resider records indicated to received the medi- after the expiration informed of the co	expiration date 12/2018. The beled with the names of 3 ints. Medication administration that the 3 residents had cations daily in the 24 days in date. The nurse was incern and pulled the eye drops went to the supply room for			Systemic Changes(s): Facility policy and proc for medication and biolo storage have been review no changes are warranted time. All licensed nurs be inserviced by the DON	ogical oed and lat thi ses will	L	

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

Event ID: C2YF11

Facility ID: VAD206

If continuation sheet Page 53 of 57

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING				
		495371	B. WING		C			
	DOLUMEN OF STREET	483571		TOTAL ADDRESS AND STATE TO CORE	01/28/2019			
NAME OF P	ROVIDER OR SUPPLIER		1	TREET ADDRESS, CITY, STATE, ZIP CODE				
HERITAG	E HALL-RICH CREEK		120 OLD VIRGINIA AVENUE					
CACAL TABLE CACALORS			R	CICH CREEK, VA 24147				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION			
(replacements. The director of nursin notified of the issue of Resident Records - I CFR(s): 483.20(f)(5). §483.20(f)(5) Reside (i) A facility may not resident-identifiable to accordance with a condance wit	ing and administrator were on 1/25/19. Identifiable Information 483.70(i)(1)-(5) Int-identifiable information. Intelease information that is to the public. Intelease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted Intelease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted Intelease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted Intelease is the information that is to an agent only in agent of the intelease is the intele	F 761	biologicals. The nursing will also be inserviced of Medication Administration	or the vill noom to the at the scip- ppro- to the tee recom- facil- and/or			

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

50 188115 G	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUCCESSION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUCCESSION (X3) DATE SUCCESSION (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUCCESSION (X4) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X5) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLIER						
		495371	B. WING _		-	01/28	3/2019
	ROVIDER OR SUPPLIER			120	REET ADDRESS, CITY, STATE, ZIP CODE D OLD VIRGINIA AVENUE CH CREEK, VA 24147		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	neglect, or domestic activities, judicial and law enforcement pur purposes, research predical examiners, a serious threat to he by and in compliance §483.70(i)(3) The farecord information a unauthorized use. §483.70(i)(4) Medicator (ii) The period of time (iii) Five years from the there is no requirem (iii) For a minor, 3 yelegal age under Stator (iii) A record of the region (iii) A record of the region (iii) The comprehen provided; (iv) The results of a and resident review determinations con (v) Physician's, nurprofessional's progressional's progressional's progressional provided; as ervices reports as This REQUIREMEI by: Based on staff intereview, and clinical failed to maintain a	violence, health oversight of administrative proceedings, poses, organ donation ourposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or all records must be retained erequired by State law; or the date of discharge when the law. The discharge when the law, or the law. The discharge when the law.	F	ロまつし	Corrective Action(s): A facility Incident and Accident form was complet for the lack of RN docume tation in medical record the pronouncement of deat occurred in the facility. Identification of Deficie Practices & Corrective Action(s): The DON and/or ADON have reviewed all deaths in th last year to identify any ative findings. All negative findings will be reported the Medical Director at the Medical Director at the Medical Director at the finding. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranthis time. All licensed ing staff will be inserved the Regional Nurse Consumon the clinical document standards per facility pand procedure. This trainwill include the standard maintaining accurate medical requirement that a Register.	when the when the when the wed to time y Inc- ll be to time wed nated at nurs- iced by ltant ation olicy ning ds for ical the	

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

Event ID: C2YF11

Facility ID: VA0206

If continuation sheet Page 55 of 57

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9 6	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	:				С
		495371	B. WING		01/28/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE	HALL-RICH CREEK			120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	
	(1) (2) (1) (2) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	\$485 C C C C C C C C C C C C C C C C C C C
F 842	The findings included. The facility staff failed nurse documented where pronounced dead. The clinical record of reviewed 1/28/19. Rethe facility 8/1/14 and Diagnoses included by Alzheimer's disease, fibrillation, atheroscletkidney disease, hypermellitus, hyperlipidem depressive disorder, a hemorrhage. Resident #117's quart (MDS) assessment were ference date (ARD) resident with a brief in 0/15. The departmental not read "Upon rounding, bed with no respiration blood pressure, no ox cool to touch and mode hands. RN (registere comfirmed (sic) findin Notified RP (responsi RP stated to send both home omitted). Signer nurse #4." The surveyor was unaby the registered nurse.	to ensure a registered men Resident #117 was esident #117 was admitted to expired 11/29/18. The profit of the prof	F 84	Nurse must document the pronouncement death when a resident exp in the facility according the acceptable profession standards and practices. Monitoring: The DON and Administrator responsible for maintaini compliance. The DON, ADO or designee will conduct audits of all residents the expire in the facility to monitor for proper document tation by a registered nu Any/all negative findings be clarified and correcte time of discovery and dis linary action will be tak needed. The results of the audit will be provided to Quality Assurance Committ for analysis and recomment ions for change in facili policy, procedure, and/or practice. Completion Date: 3/12/1	are ng N and/ chart hat n- rse. will d at ccip- en as his the ee dat- ty
10 mm 1 mm 10 mm 1	by the registered nurs in the clinical record.	se of Resident #117's death			

PRINTED: 02/06/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TPLE CONSTRUCTION NG		MPLETED C			
		495371	B. WING_			01/28/2019		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 842	(DON) of the above a.m. The DON was documentation by the death. The DON statespecially the RN or expired to documentation from 1/28/19. The surveyor review "Charting and Documentation good policy read in part "to be documented in d. Changes in the result of the DON was a surveyor review of the result of the document of the result of the result of the result of the DON was a surveyor review of the result	ed the director of nursing issue on 1/28/19 at 11:56 unable to locate he RN of Resident #117's ated she would expect staff in duty when Resident #117 their findings. In their findings on the director of nursing on the director of nursing on wed the facility policy titled imentation" on 1/28/19. The 2. The following information is in the resident medical record: esident's condition."	F	842				

FORM CM\$-2567(02-99) Previous Versions Obsolete

Jerement Fruh
Administrator

2-13-107