State of V		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		VA0102	B. WING		03/21/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE	
HERITAGE	HALL GRUNDY		ATE CREEK ROA	D	
			Y, VA 24614	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETE
F 000	Initial Comments		F 000		
	survey and biennial swas conducted 03/19 Corrections are requirements and Virgor the Licensure of Safety Code survey/ The census in this 12 at the time of the	rginia Rules and Regulations Nursing Facilities. The Life report will follow. 20 certified bed facility was a survey. The survey sample ent Resident reviews and 3			
F 001	Non Compliance		F 001		
	-	of compliance with the sure requirements:		F 001 Resident Rights 12 VAC 5-371-150 (A, B, C) – Cros References to F550 and F565	S
	This RULE: is not m The facility was not i	it compliance with the		Cross Reference to POC for F550 an	d F565
	Licensure of Nursing			Nursing Services 12 VAC 5-371-220 H - Cross References F580	ence to
	Resident Rights 12 VAC 5-371-150 (F550 and F565	A, B, C)- cross reference to		Cross Reference to POC for F580	
	Resident Rights 12 VAC 5-371-220 H - Cross Reference to F580 Cross Reference to POC for F580	erence to			
	Policies and Proced 12 VAC 5-371-140 (F623, F625	ure D)-cross reference to F622,		Cross Reference to POC for F622, I F625	623,
	Nurse Staffing	A.2)-cross reference to F658		Nurse Staffing 12 VAC 5-371-210 (A.2) - Cross R to F658	eference
	Nursing Services			Cross Reference to POC for F658	
LABORATORY		R/SUPPLIER REPRESENTATIVE'S SIGNAT	URE	Administration	(X6) DATE 4/22/1

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State of Virginia

State of	viigiiia						
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		VA0102	B. WING		03/2	21/2019	
NAME OF F	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STAT	E, ZIP CODE			
HERITAG	E HALL GRUNDY		LATE CREEK ROAI DY, VA 24614	D			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
F 001	12 VAC 5-371-220-ci F695, F759 Pharmaceutical Serv 12 VAC 5-371-300 (A Clinical Records 12 VAC 5-371-360-ci Infection Control 12 VAC 5-371-180-ci Maintenance and Ho 12 VAC 5-371-370 (B and F921 Laundry Services	ross reference to F684, rices A)-cross reference to F761 ross reference to F842 ross reference to F880	F 001	Nursing Services 12 VAC 5-371-220 Cross R F684, F695, F759 Cross Reference to POC for F759 Pharmaceutical Services 12 VAC 371-300 (A) - Cros F761 Cross Reference to POC for Clinical Records 12 VAC 371-360 - Cross Re Cross Reference to POC for Infection Control 12 VAC 371-180 - Cross Re Cross Reference to POC for Maintenance and Houseke 12 VAC 371-370 (B) - Cros F584 and F921 Cross Reference to POC for Laundry Services 12 VAC 371-380 Cross Reference to POC for Cross Reference to POC for Completion Date: 5/5/19	F684, F695, as Reference to F761 eference to F842 F842 eference to F880 eping as Reference to F584, F921 ference to F880		

PRINTED: 04/11/2019 FORM APPROVED OMB NO. 0938-0391

CENTERS	FOR MEDICARE &	MEDICAID SERVICES				- I	. 0938-0391
STATEMENT OF	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CON	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			
		495259	B. WING			03/	21/2019
NAME OF PR	OVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				2966	SLATE CREEK ROAD		
HERITAGE	HALL GRUNDY			GRU	NDY, VA 24614		I
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	survey was conducte 03/21/2019. The fac compliance with 42 (Requirement for Lon	g-Term Care Facilities. No vestigated during the survey.	F	000	-		
	survey was conduct 03/21/19. Correction	s are required for compliance 3 Federal Long Term Care Life Safety Code		And the state of t			
	112 at the time of the consisted of 23 currollosed record review	ercise of Rights	F.	550	F550 Corrective Action:		
SS=D	§483.10(a) Residen The resident has a self-determination,		To the state of th	The second secon	The facility has identified an alter location for Resident Council to mensure that privacy is maintained their meetings.	eet to during	
	outside the facility, this section.	ncluding those specified in	The second secon		Identification of Deficient Pract Corrective Action(s): All other residents may have pote been affected. The Activities dire review the Resident Council Min	ntially ctor will	
	with respect and digresident in a manne promotes maintena her quality of life, re individuality. The far promote the rights	gnity and care for each or and in an environment that noe or enhancement of his or cognizing each resident's cility must protect and			the previous 90 days to identify r with concerns or complaints abou privacy not being maintained dur resident council meeting. Any/all concerns noted will be reviewed administrator for any corrective a that may be needed.	esidents it ing the with the	(X6) DATE

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

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED
		495259	B. WING		03/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 550	§483.10(a)(2) The fa access to quality can severity of condition, must establish and manager provision of services residents regardless. §483.10(b) Exercise The resident has the rights as a resident or resident of the Universident can exercise interference, coerciof from the facility. §483.10(b)(1) The faresident can exercise interference, coerciof from the facility. §483.10(b)(2) The refree of interference, reprisal from the facility and to be suppexercise of his or he subpart. This REQUIREMENT by: Based on resident of interview, and facility staff failed to ensure resident council to manager the findings included volunteers and residents and residents interrupted on three (3) different the findings included volunteers and residents are residents.	cility must provide equal e regardless of diagnosis, or payment source. A facility maintain identical policies and ransfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her of the facility and as a citizen ited States. cility must ensure that the e his or her rights without in, discrimination, or reprisal esident has the right to be coercion, discrimination, and lity in exercising his or her rights as required under this. T is not met as evidenced exouncil interview, staff y document review, the facility is a private location for the neet. Volunteers and it her resident council meeting it occasions.	F 55	Systemic Change(s): The facility policy and procedure been reviewed and no changes ar warranted at this time. All staff vinserviced by the Social Services and/or Activities Director on Res Rights and Dignity to include the procedure to be maintained durin Resident Council meetings A stamember has been asked to attend resident council meeting to superensure that resident privacy and are maintained during the meeting. Monitoring: The Administrator is responsible compliance. The Administrator a Activities Director will monitor Resident Council Meeting to ensist findings will be corrected immeand disciplinary action will be tawarranted. Aggregate findings reported to the Quality Assurance Committee for review, analysis, recommendations for changes in procedure, and/or facility practice. Completion Date: 5/5/19	vill be vill be Director sident proper ag all ff I the rvise and dignity ag. for and/or the sure that agnity of ve diately, aken as will be ce and a policy,

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES				OVEN DATE	C1 10/10/
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			INSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495259	B. WING _			03/	21/2019
	OVIDER OR SUPPLIER			2966	ET ADDRESS, CITY, STATE, ZIP CODE SLATE CREEK ROAD JNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 550	On 3/20/19 at 11:00 group of the facility rattended the resider. The assistant activity both entrances to the Immediately after pland before the active residents came through entrance, walked to went to the outside of the At 11:11 a.m., a resident council meeting from pedaled the wheeld and exited the main with the help of a set the door for the resident sitting in the came in, walked to resident sitting in the main entrance door apologized for community of the surveyor informative of the above meeting on 3/20/19	a.m., the surveyor met with a residents. Seven residents at council meeting. y director placed signs on e dining room at 11:07 a.m. acing the signs on the door ity assistant left the room, two ugh the main dining room the end of the room, and deck area. ident entered the resident in the rehab side entrance, hair through the dining room entrance to the dining room entrance to the dining room entrance to the dining room entrance and walked to the area set up. unteer entered the dining entrance. The volunteer the kitchen door, took the er Geri chair out through the r, then came back, and ing in. med the administrator, the and the corporate registered concern in the end of the day	F	550			
F 565		roup and Response	***	565	F565 Corrective Action(s):		

STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY OMPLETED
		495259	B. WING				03/21/2019
	PROVIDER OR SUPPLIER			296	REET ADDRESS, CITY, STATE, ZIP CODE 56 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 565	Section (1) CFR(s): 483.10(f)(5) The rand participate in record (i) The facility must group, if one exists reasonable steps, to make residents a upcoming meeting: (ii) Staff, visitors, or resident group or facility must person who is appropriate approviding assistance requests that result (iv) The facility must request that result (iv) The facility must resident or family (in) the grievances and groups concerning in the facility. (A) The facility must imple request of the resident of the residents of the residents of the residents of the residents in families or resider residents in the facility in the facility must imple request of the residents in the family member(s) representative(s) families or resider residents in the facility REQUIREMED (ii) The residents in the facility REQUIREMED (iii) The residents in the facility REQUIREMED (iiii) The residents residents in the facility REQUIREMED (iiii) The residents residen	esident has a right to organize esident groups in the facility. It provide a resident or family with private space; and take with the approval of the group, and family members aware of is in a timely manner. It other guests may attend amily group meetings only at up's invitation. It provides a designated staff roved by the resident or family lity and who is responsible for the and responding to written the from group meetings. It from group meetings are consider the views of a group and act promptly upon the recommendations of such the sisues of resident care and life to the able to demonstrate their conale for such response. It be construed to mean that the ment as recommended every dent or family group. The sident has a right to have or other resident meet in the facility with the interpresentative(s) of other	F	565	The Activity Director and the Act Assistant have received inservice on the requirement that all grievances&concerns must be act promptly by the facility when the are resident care and quality of lirelated. Identification of Deficient Pract Corrective Action(s): All other residents may have been potentially affected. The Activity will meet with the Resident Courreview theResident Rights Policy regarding Grievances & Concern process to be followed. Systemic Change(s); Facility policy and procedure was reviewed and no changes are was this time. The Activity Director was reviewed and no changes are was this time. The Activity Director was reviewed and requirement that all grievances & Concerns policy with all Department Head Staff to ensure they are awagrievance & Concern policy and requirement that all grievances & Concerns related to their specific departments will be acted upon pand returned to the Activity Director with the administrator and resident(s). Monitoring: The Activity Director is responsis maintaining compliance. The Activity Director will review resident couminutes monthly and the grievant weekly to monitor for any reside concerns not acted upon. Any/all findings will be reported to the Administrator for immediate coraction to include an investigation Completion Date: 5/5/19	ted upon testissues fe tice(s) & n Director neil and r as and the ss rranted at will cnent are of the the coromptly cotor for d the tible for ctivity uncil ace log ent l negative rective	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	
495259 B. WNG	03/21/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614	·
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD PREFIX CROSS-REFERENCED TO THE APPLICATION DEFICIENCY)	IOULD BE COMPLETION
F 565 Continued From page 4 interview, and facility document review, the facility staff falled to act upon grievances/concerns from the December 2018 resident council meeting. The findings included: The surveyor obtained the resident council minutes from December 2018, January 2019 and February 2019 during the entrance conference on 3/19/19 from the administrator. The resident council president was identified as Resident #58. On 3/20/19 at 11:00 a.m., the surveyor met with a group of the facility residents. Part of the interview included review of the previous three months resident council minutes and discussion of the minutes with the group. Seven residents attended the resident council meeting. Issues from the December 2018 resident council meeting minutes were as follows: one resident wanted her clothing rack lowered. The barrels are loud. One resident wanted another lift and wanted different food and one resident wanted the closet neater. The surveyor asked the group if the concerns identified in the resident council minutes were addressed and followed up with the group. Resident #58 stated the facility doesn't act promptly on concerns. Resident #58 stated, "The group tells me and we discuss it and we bring it up at the next meeting. The barrels/trash cans are still an issue. They wake everybody up at night." The minutes reflected that in December 2018 both the activity director and the assistant activity director attended the resident council meeting.	

	FOR WEDIOARE W		0/0) 48 8	DDLC C	ONSTRUCTION	(X3) DATE S	URVEY
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DISTRUCTION	COMPLI	
		495259	B. WING			03/2	1/2019
MANE OF DO	OVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF FR	OVIDER OR SOFT LIER			l	6 SLATE CREEK ROAD		
HERITAGE	HALL GRUNDY			GR	RUNDY, VA 24614		
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F 565	Continued From page	e 5	F	565			
	The January 2019 re reviewed. The surve documentation of the December 2018 mee	follow-up from the		Adams and the second se			
	director of nursing, a nurse of the above o meeting on 3/20/19 a administrator stated	the activity staff fill out the ke it to the dept and then		ALL MARKET TO THE ALL ALL MARKET TO THE ALL ALL ALL ALL ALL ALL ALL ALL ALL AL			
	3/21/19 at 7:15 a.m. noise from the barrel new barrels had bee asked if the surveyo department respons not. The administra the responses from the December 2018 department involved and then gives the recorrect the concern.	e forms. The surveyor had tor provided the surveyor with the identified concerns from meeting and stated the I was given the concern form esponse what was done to The issue concerning the lels was never addressed the		THE PROPERTY OF THE PROPERTY O	RECEIN APR 25 X VDH/O	2019	
F 580 SS=D	exit conference on 3 Notify of Changes (CFR(s): 483.10(g)(§483.10(g)(14) Noti (i) A facility must im consult with the res	njury/Decline/Room, etc.)		F 580	F580 Corrective Action(s) Resident #160's representative was notified that facility failed to notify when an antibiotic was ordered to t UTI by the nurse practitioner. A Fa Incident & Accident form has been completed for this incident.	them reat a scility	

CENTER	S FOR MEDICARE &	WEDICAID SERVICES			A CONTRACTOR	(X3) DATE	SURVEY
STATEMENT OF AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
•		495259	B. WING			03/	21/2019
	ROVIDER OR SUPPLIER			296	REET ADDRESS, CITY, STATE, ZIP CODE 56 SLATE CREEK ROAD RUNDY, VA. 24614		
(X4) ID PREFIX TAG	SUMMARY S	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	representative(s) who (A) An accident involves in injury and physician intervention (B) A significant characterioration in heal status in either life-to clinical complication (C) A need to alter that a need to discontinutereatment due to adcommence a new form (D) A decision to transident from the fall \$483.15(c)(1)(ii). (ii) When making not (14)(i) of this section all pertinent informatis available and prophysician. (iii) The facility must resident and the re	nen there is- living the resident which has the potential for requiring on; onge in the resident's physical, ocial status (that is, a th, mental, or psychosocial hreatening conditions or os); reatment significantly (that is, oue an existing form of verse consequences, or to orm of treatment); or onsfer or discharge the cility as specified in otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the out also promptly notify the sident representative, if any, out or roommate assignment on. out of the sident representative, if any, out or roommate assignment on. out record and periodically out in the sident regresent or out of the sident re	F 5	680	Identification of Deficient Practice & Corrective Action(s): All other residents with physician or antibiotic orders may have potential been affected. The DON, ADON an Unit Managerwill complete a 100% review of all resident physician ordered identify all antibiotics ordered to identify all antibiotics ordered to idensident at risk. All negative finding be corrected at the time of discovery the Resident Representatives will be notified. A facility Incident & Accident form has been completed for this in Systemic Change(s): The facility policy and procedure here the reviewed and no changes are warranted at this time. The 24 Hour Report serves as the source docume communicating changes in conditions tatus, proper notification to the attraction physicians and the responsible part revision/updates to the comprehens plan of care. The 24 Hour Report verviewed and initialed daily by the Administrator, DON and Unit Manager. The Licensed staff will be inserviced by the DON and/or Regnurse consultant on the Notification Rights & Services and issued a cop the facility policy and procedure. inservice will include staff education Physician and RP notification for a changein resident status, medication treatments.	dered ly d or ers, to entify gs will y and edent cident. as ent for on, ending ies and sive vill be e ional n of oy of The on on any	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE S COMPL	
		495259	B. WNG			03/2	1/2019
•	ROVIDER OR SUPPLIER E HALL GRUNDY			2	TREET ADDRESS, CITY, STATE, ZIP CODE 966 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	its physical configura locations that compripart, and must specif room changes between under §483.15(c)(9). This REQUIREMENT by: Based on staff intervereview, and clinical related to inform the rechange in condition for (Resident #160). The findings included The facility staff failed responsible party of the facility 12/18/14 diagnoses that including affecting left non-dougled cardiomegaly, hyper hyperlipidemia, anxiour opathy, acute upper membolism and throm extremities. Resident #160's 30 with an assessment 2/5/19 assessed the memory problems, is and moderately impledecision making-decision making-decision.	tion, including the various se the composite distinct by the policies that apply to en its different locations It is not met as evidenced view, facility document ecord review, the facility staff esident representative of a for 1 of 26 residents It dies to inform Resident #160's a new order for an antibiotic. If Resident #160 was admitted 8 and readmitted 1/7/19 with ded but not limited to cerebral a following cerebral infarction minant side, ST elevation,	F	580	Monitoring: The DON and Unit Managers are responsible for maintaining compliant Daily audits of physician orders will be completed to identify residents with physician ordered antibiotics to monit compliance. All Any/all negative find will be corrected at time of discovery appropriate disciplinary action taken. Aggregate findings will be reported to QA Committee for review, analysis at recommendation for changes in facility policy, procedure and/or practice. Completion Date: 5/5/19	or ings and o the	

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE : COMPL	MPLETED	
		495259	B. WING _			03/2	1/2019	
	ROVIDER OR SUPPLIER			296	REET ADDRESS, CITY, STATE, ZIP CODE 56 SLATE CREEK ROAD RUNDY, VA 24614			
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	culture-one found in record and one found record. The results found in F an order written by the Cipro 500 mg (millight days and was dated found in Resident #16 "No new orders-NP's (?19)." The surveyor reviewed 1/15/19 departmental documentation the rewas informed of the rewas informed of the resurveyor requested the foliation of the representative about director of nursing states. The policy titled "Chacondition or Status" otherwise instructed notify the resident's reis a significant change.	ulture/sensitivity dx a. two results of the urine Resident #160's clinical I in Resident #46's record had ne nurse practitioner (NP) for ams) q12 (every) 12 x 5 1-14-19. The culture result 60's laboratory section read ignature and dated 1-15-18 ed the 1/14/19 through I notes and found no esident's responsible party medication order. ed the director of nursing of a 3/21/19 at 10:19 a.m. The ne facility policy on change on on 3/21/19. Asked if staff otifying the resident's medication changes, the ated yes. ange in a Resident's read in part "4. Unless by the resident, a nurse will epresentative when b. There e in the resident's physical,	F	580				
F 584	exit conference on 3/	n was provided prior to the	F	584	F584 Corrective Action(s): The Linen Barrels used to transport so linen in the facility that were very nois have been replaced.			

ABUDING ABUDING ABUDING ABUDING BY ABUDING		OF DESIGNATION	(X1) PROVIDER/SUPPLIER/CLIA	IA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
TREET ADDRESS, CITY, STATE, 2P CODE 286 SLATE CREEK ROAD GRUNDTY, A 24614 PREFIX TAG SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICENCY MUST BE PRECEDED BY FULL PREFIX TAG F 584 Continued From page 9 F 584 Continued From page 9 GRINDTY, AS 10()(1)(7) S483,10()(1)(7) The resident has a right to a safe, clean, comfortable and homelike environment. The resident has a right to a safe, clean, comfortable and homelike environment and supports for daily living safely. The facility must provide- §483, 10()(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safely risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483,10()(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interfor; §483,10()(3) Clean bed and bath linens that are in good condition; §483,10()(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483,10()(5) Adequate and comfortable lighting levels in all areas;				1 ' '			COM	YLE I ED
NAME OF FROMDER OR SUPPLIER HERITAGE HALL GRUNDY O(4) ID PREFERX TAG SUMMARY STATEMENT OF DEPROSENCES BY YILL (SCAP) OF DEPROSENCES OF YILL (SCAP) OF DEPROSENCES OF YILL (SCAP) OF THE APPOPRIATE DEPROSENCE OF THE APPOPRIATE DEPOSENCE OF TH			495259	B. WING			03	/21/2019
### HERITAGE HALL GRUNDY 298 SLATE CREEK ROAD GRUNDY, VA 24614	NAME OF DE	OVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAGS					296	66 SLATE CREEK ROAD		
PRIETIX TAG FS84 Continued From page 9 SS=C FF(8): 483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, lincluding but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility smaximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	HERITAGE	HALL GRUNDY			GR	RUNDY, VA 24614		
Sec Continued From page 9 CFR(s): 483.10(i)(1)-(7) \$483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving freatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREF	- 1	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	ILD BE	COMPLETION
§483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and		CFR(s): 483.10(i)(1) §483.10(i) Safe Environment of the resident has a recomfortable and hor but not limited to recomports for daily live. The facility must prospect of the facility shall the protection of the facility shall th	ironment. ight to a safe, clean, melike environment, including ceiving treatment and ing safely. ovide- o, clean, comfortable, and ent, allowing the resident to enal belongings to the extent suring that the resident can envices safely and that the de facility maximizes resident does not pose a safety risk. exercise reasonable care for e resident's property from loss ekeeping and maintenance to maintain a sanitary, orderly, erior; a bed and bath linens that are the closet space in each expecified in §483.90 (e)(2)(iv); uate and comfortable lighting fortable and safe temperature tially certified after October 1,	F	584	and Corrective Action(s): All other residents may have pote been affected. A complete documenvironmental walkthrough of the will be conducted by the administ and environmental services directly identify resident areas that have provided in the use cleaning and transport equipment resident areas identified with potenoise concerns from cleaning and transport equipment will be immore reviewed for corrections to control levels. Systemic Change(s): The facility's policy & procedure providing a safe, sanitary, and comfortable environment has be reviewed. No changes are warrathis time. The Maintenance Director provide inservices to all staff on policy and procedure on the not system to use when repairs are a throughout the facility to eliming correct problems with cleaning transport equipment that are can concerns in the resident care are maintenance request logs will be reviewed by the administrator of the control of the cont	entially mented e facility strator tor to potential of t. All tential d tediately rol noise re for the facility strator to to potential of to the facility color facility diffication facility diffic	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495259	B. WING			03/2	21/2019
	ROVIDER OR SUPPLIER HALL GRUNDY			29	REET ADDRESS, CITY, STATE, ZIP CODE 66 SILATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 584	sound levels. This REQUIREMEN by: Based on observati staff interview, and of facility staff failed to level in the building. The findings include The facility staff faile sound level. Trash the staff rolled them each of the units co linens. During the survey, of residents on both un barrels was noticea conversation becaut hear what the reside interviewed Resider a.m. Resident #79 interview how the n resident stated, "Th down the hall." Resident stated, "Th down the hall." Resident from we noise from the barrel The surveyor obtain minutes from Decer February 2019 duri 3/19/19 from the ac council president we On 3/20/19 at 11:00	e maintenance of comfortable IT is not met as evidenced on, resident council interview, facility document review, the ensure a comfortable sound ed: ed to maintain a comfortable cans/barrels were noisy when up and down the halls on flecting trash and soiled four surveyors interviewed nits. The noise made from the ble often-interrupting se the surveyor could not ent was saying. The surveyor nt #79 on 3/19/19 at 11:44 was asked during the oise in the facility was and the e barrels are loud when rolling sident #79 was interviewed in vith the door closed; however,	F	584	Monitoring: The Environmental Director and the Maintenance Director is responsible maintaining compliance. Documente facility rounds will be completed were to monitor compliance. The administ will review weekly to ensure negative findings are being corrected. Cumula findings will be reported to the Quali Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice Completion Date: 5/5/19	d kly rator e tive	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		re Survey Mpleted
		495259	B. WING			3/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP COD 2966 SLATE CREEK ROAD GRUNDY, VA 24614	E	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 584	interview included a months resident coun of the minutes with the attended the resident one issue from the Council meeting minuterels. The surveyor asked identified in the resident #58 stated promptly on concern group tells me and vup at the next meetin are still an issue. The minutes reflected both the activity director attended the the surveyor inform director of nursing, nurse of the above meeting on 3/20/19 The administrator in 3/21/19 at 7:15 a.m. noise from the barrenew barrels had be asked the administrator asked the department resinot. The administrator asked the responses from the response from	review of the previous three noil minutes and discussion ne group. Seven residents to council meeting. December 2018 resident utes was the loudness of the the group if the concerns dent council minutes were wed up with the group. The facility doesn't act as. Resident #58 stated, "The we discuss it and we bring it and. The barrels/trash cans ney wake you up at night. wake everybody up at night." The district that in December 2018 actor and the assistant activity are resident council meeting. The district that in December 2018 actor and the assistant activity are resident council meeting.	F 58	4		

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495259	B, WING_			03/2	1/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			296	REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 584	and then given the reconcerning the loudn addressed, the adminimation exit conference on 3. Transfer and Dischart CFR(s): 483.15(c)(1) \$483.15(c)(1) Facility (i) The facility must premain in the facility, discharge the reside (A) The transfer or discharge the resident's welfare an cannot be met in the (B) The transfer or discharge the resident's welfare and cannot be met in the (B) The transfer or discharge the resident's welfare and cannot be met in the (B) The transfer or discharge the resident sufficiently so the reservices provided by (C) The safety of incompanies of the resident (D) The health of incontent of the resident has appropriate notice, the under Medicare or Monpayment applies submit the necessal	was given the concern form esponse. The issue ess of the barrels was never nistrator stated. In was provided prior to the (21/19. The regular regula	A Party Community Communit	622	F622 Corrective Action(s): The facility staff failed to provide the receiving Hospital with the approprisinformation related to the resident transfer. The facility did not send coninformation for the attending physician, contact information for the Resident Representative, Advance directive information, instructions for ongoing care, comprehensive care plingoals and discharge summary. The falso failed to document the information provided to the receiving hospitalfor Residents #2, #44, #46, #72 and #11 facility Incident & Accident Form has been completed for each resident involved. Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have been affected. The DON/designeews conduct a 100% audit of all residents have been discharged and/or transfer from the facility in the past 30 days to	r an acility on	
	Medicare or Medicaresident refuses to president who become admission to a facility	e third party, including id, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ty, the facility may charge a able charges under Medicaid;			identify residents that did not have the required documentation submitted to receiving facility. A facility Incident Accident Form will be completed for negative finding.	the &	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		495259	B. WING		03/21/2019	
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 622	or (F) The facility cease: (ii) The facility may not resident while the apply 431.230 of this charge notice from 431.220(a)(3) of this discharge or transfer or safety of the reside facility. The facility methat failure to transfer when the facility transfer or safety of the resident under any of in paragraphs (c)(1)(is section, the facility more discharge is documedical record and a communicated to the institution or provider (i) Documentation in must include: (A) The basis for the (i) of this section. (B) In the case of parasection, the specific of the service facility to meet the net (ii) The documentation (2)(i) of this section in (A) The resident's phedischarge is necessar (A) or (B) of this section when the service (B) A physician where	s to operate. of transfer or discharge the beal is pending, pursuant to opter, when a resident ight to appeal a transfer or in the facility pursuant to § chapter, unless the failure to would endanger the health ent or other individuals in the must document the danger or discharge would pose. The circumstances specified (A) through (F) of this ust ensure that the transfer mented in the resident's ppropriate information is receiving health care. The resident's medical record transfer per paragraph (c)(1) agraph (c)(1)(i)(A) of this resident need(s) that cannot opt to meet the resident pet to meet the resident pet of the required by paragraph (c) in required by paragraph (c) in required by paragraph (c) in ust be made by-ysician when transfer or ary under paragraph (c) (1)	F 62	Systemic Change(s): Facility policy and procedures have be reviewed. No revisions are warranted this time. The DON and/or Regional Nurse Consultant will inservice facilitylicensed staff and social service on the documentation required to be submitted to the receiving facility whe resident is being transferred or dischat to the hospital or other outside health facility/provider. Monitoring: The DON/designee will be responsible maintaining compliance. The DON are designee will conduct chart audits we of all residents who have been dischat and/or transferred from the facility to monitor for compliance. Any/all negating and or errors will be corrected time of discovery. Aggregate finding these audits will be reported to the Quality Assurance Committee quarter for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 5/5/19	es en a rged care e for ad/or ekly rged ative d at s of	

Facility ID: VA0102

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495259	B, WING			3/21/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 2966 SLATE CREEK ROAD GRUNDY, VA 24614	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 622	this section. (iii) Information provemust include a minir (A) Contact information responsible for the contact information (C) Resident representation (C) Advance Direction (D) All special instruongoing care, as applicable, to entransition of care for #2, Resident #110. The findings included including contact in the findings including care for #2, Resident #110. The findings including contact in the findings including care for #110. The findings including the findings including care for the findings including care for #2, Resident #110.	ided to the receiving provider num of the following: ion of the practitioner care of the resident. Interestive information including we information including we information including over information including a verification of propriate. In care plan goals; is discharge summary, including a verification, as applicable, and tation, as applicable, to ensure interestion of care. It is not met as evidenced arview, facility document review review, the facility staff failed aving provider with information intact information of the representative information formation, Advance Directive information, Advance Directive information, appropriate, comprehensive in all other necessary in gray a copy of the resident's sy, consistent with §483.21(c) and any other documentation, insure a safe and effective for 5 of 26 residents (Resident #72, i).	F	622		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495259	B. WING			03/2	1/2019
, , , , , , , ,	ROVIDER OR SUPPLIER E HALL GRUNDY			296	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614		
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 622	provider information of name of the practition resident representative advanced directive in ongoing care, the corgoals, and the dischast aff failed to docume information was provided for Resident #2. The clinical record of 3/19/19 through 3/21 admitted to the facilite 2/26/19. Diagnoses acute cellulitis right fright great toe, probadisease, diabetes me esophageal reflux, hyconvulsions, anxiety, disturbances, hyperlia Alzheimer's disease, Resident #2's quarte with an assessment 12/11/18 assessed the memory problems, leand severely impaired decision-making. The departmental no read "LE (late entry) to transport res (resiomitted). Informed by (medical doctor) war (name of hospital on cellulitis of Rt. (right) hospital was notified.	for care of Resident #2-the ner at the nursing home, the we contact information, iformation, instructions for imprehensive care plan arge summary. The facility ent in the clinical record what ided to the receiving provider Resident #2 was reviewed /19. Resident #2 was y 10/11/12 and readmitted included but not limited to not with infected ulceration of oble peripheral vascular ellitus type II, atrial fibrillation, ypertension, dysphagia, dementia without behavioral includentia, anemia, and seizure disorder. In minimum data set (MDS) reference date (ARD) of the resident with short-term tong-term memory problems, and cognitive skills for daily onte dated 2/26/19 at 2:34 p.m. from 0900: Rescue 33 here dent) to (name of hospital by night shift nurse that MD into the resident of the country and the countr	F	622			

CENTER	S FOR WILDICANE &	T CONTROL OF THE STATE OF THE S	(X3) DATE SUR			HIDVEV	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COMPL	
		495259	B. WING			03/2	1/2019
	ROVIDER OR SUPPLIER HALL GRUNDY			29	REET ADDRESS, CITY, STATE, ZIP CODE 166 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES IY 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 622	The surveyor spoke of nurse on 3/20/19 at a was sent to the hosp transferred. The corporation was sent to the social worker. The social worker completes the social worker. The social worker was admandated to the resident was admandated to the social after a form titled "Heritage Discharge/Transfer and understand that I am Heritage Hall Grundreason for the transfiphysician for direct a Resident in (name of Copy mailed to RP (2/28/19." The social no information to the was transferred 2/26	with the corporate registered 10:24 a.m. what information ital when residents are porate RN stated the social at. The surveyor interviewed he social worker was asked as sent with the resident when nitted to the hospital on worker provided the surveyor he Hall Grundy Form." The form read, "I he being discharged from y. I understand that the fer is recommendation of admission to hospital. If hospital omitted) 2/27/19. If responsible party) on I worker stated he provided thospital when Resident #2	F	622			
	The corporate RN in at 10:30 a.m. a transfors/dischar The facility policy tit Notice" read in part resident representatin writing of the folloa. The reason for the b. The effective date	was blank. Informed the surveyor 3/20/19 Informed the surveyor 3/20/19 Informed the surveyor 3/20/19 Informed the surveyor 3/20/19 Informed the facility policy Information the surveyor of the transfer or discharge Information the surveyor 3/20/19 Informatio					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495259	B. WING_			03/21/2019	
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP COD 2966 SLATE CREEK ROAD GRUNDY, VA 24614	É		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 622	d. A statement of the the transfer or discha (1) the name, ad number of the entity requests; (2) information a and submit an appea (3) how to get as appeal process; e. The facility bed-ho. The surveyor informedirector of nursing, an nurse of the above in No further information exit conference on 3/12. The facility staff fare provider with contact practitioner caring for representative contact directive information, ongoing care, the contact of the distortion of the distortion of the distortion of the distortion of the facility 11/29/16 and 1/5/19 but not limited to her infarction affecting le hepatomegaly, dyspireflux disease, arthowith new onset type multifocal pneumonic	resident's rights to appeal arge, including; ldress, email and telephone which receives such about how to obtain, complete all form; and esistance completing the ald policy; and the administrator, the and the corporate registered afformation on 3/21/19. In was provided prior to the 1/21/19. In was provided prior to the 1/21/19. In alled to provide the receiving and information of the arther resident, the resident any special instructions for any special and the	F6	522			
		a, acute renal failure e depletion, hypertension,					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED		
		495259	B. WING			3/21/2019
•	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	hyperlipidemia, urina methicillin sensitive sand history of seizure Resident #44's 30-da assessment with an (ARD) of 2/3/19 asse interview for mental structure for mental struct	ary tract infection with Staph aureus, hyponatremia, e disorder. By minimum data set (MDS) assessment reference date essed the resident with a brief status as 15/15. By evaled a departmental note read in part Resident #44 unt of brown substance. Call who ordered the resident to hospital. The order dated sfer to (name of ency room) for eval estion, N/V (nausea/vomiting) pressure) 130/76, T	F 62			
	transferred to the en The surveyor intervit on 3/21/19 at 11:29 when Resident #44 emergency room. Resident #44's face December 2018 dep 2019 departmental is transfer/discharges. The facility policy tith Notice" read in part resident represental in writing of the follo	nergency room. ewed the director of nursing a.m. of the above concern was transferred to the The surveyor requested sheet, MDS, care plan, partmental notes, January notes and the facility policy for led "Transfer or Discharge "3. The resident and/or tive (sponsor) will be notified				

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495259	B. WING			03/2	1/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY	•		2	TREET ADDRESS, CITY, STATE, ZIP CODE 1966 SLATE CREEK ROAD 12 RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	b. The effective date c. The location to wh transferred or discha d. A statement of the the transfer or discha (1) the name, ac number of the entity requests; (2) information a and submit an appea (3) how to get a appeal process; e. The facility bed-ho No further informatio exit conference on 3 3. The facility staff fa provider information name of the practitic resident representat advanced directive i ongoing care, the co goals, and the disch staff failed to docum information was pro for Resident #46. The clinical record of 3/19/19 through 3/2 admitted to the facil 9/21/07 with diagno non-displaced fract fibula, non-traumatic constipation, gastro hypertension, Vitam benign prostatic hyp	of the transfer or discharge ich the information is being reged resident's rights to appeal arge, including; ddress, email and telephone which receives such about how to obtain, complete al form; and ssistance completing the old policy; on was provided prior to the d/21/19. Alied to provide the receiving for care of Resident #46-the oner at the nursing home, the ive contact information, instructions for comprehensive care plan arge summary. The facility tent in the clinical record what vided to the receiving provider of Resident #46 was reviewed 1/19. Resident #46 was ity 6/27/17 and readmitted	F	622			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495259	B. WNG		03/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP COD 2966 SLATE CREEK ROAD GRUNDY, VA 24614	E
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 622	Continued From pa	ge 20	F 6:	22	
	data set (MDS) ass reference date (AR resident with a BIM status) as 15/15. The surveyor interv 3/20/19. When ask falls, Resident #46 his ankle, and state broke his ankle. The surveyor revied dated 1/24/19 at 12 (late entry) from 09 walkin (sic) down his walking outside and but I'm okay. Asset to RT (right) ankle, and FNP (family nuand gave order for outside walking dunotified and res is The 1/24/19 6:06 pt "Late entry for 170 x-rays and gave or (emergency room) (at) 1712 (5:12 p.n services here @ the (name of hospital report. Resident cand no visible sign.)	ificant change in minimum essment with an assessment D) of 2/6/19 assessed the S (brief interview for mental siewed Resident #46 on a sed if the resident had any raised his right leg, pointed to ad he slipped in the snow and swed the departmental note 2:00 p.m. The note read "LE 100: Res (resident) came all to nurse and stated "I was ad slipped and hurt my ankle assment reveals swollen area Instructed res to elevate leg urse practitioner) was notified x-ray. Instructed rest to not be to inclement weather. FNP own RP (responsible party)." b.m. departmental note read 0 (5:00 p.m.) FNP notified of of the state of the sed of the state of distress noted." unable to locate documentation of of information sent to the state of th			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG		MPLETED
		495259	B. WNG_			3/21/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 622	Continued From pag	e 21	F	522		
	nurse of the above c p.m. and asked when located when the res emergency room. The transfer forms had no surveyor requested t transfers/discharges					
	Notice" read in part " resident representati in writing of the follow a. The reason for the b. The effective date c. The location to wh transferred or discha d. A statement of the the transfer or discha (1) the name, ac number of the entity requests; (2) information a and submit an appear	e transfer or discharge of the transfer or discharge ich the information is being irged e resident's rights to appeal arge, including; ddress, email and telephone which receives such about how to obtain, complete al form; and ssistance completing the				
	No further information exit conference on 3 4. The facility staff for provider information name of the practition resident representation advanced directive in ongoing care, the conference on the conference of	n was provided prior to the				

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & MEDICARD SERVICES					a contraction	(X3) DATI	E SURVEY
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	COMPLETED	
		495259	B. WING_			03	/21/2019
	ROVIDER OR SUPPLIER			296	REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614		
HEIMINGE					PROVIDER'S PLAN OF CORRE	CTION	(X5)
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	COMPLETION DATE
F 622	staff failed to documinformation was proving for Resident #72. The clinical record of 3/19/19 through 3/2 admitted to the facility 9/24/18 with diagnost limited to above the diastolic heart failure pulmonary disease, gastro-esophageal in hypothyroidism, Vita muscle weakness, of varicose veins of left diabetes mellitus, and Resident #72's sign data set (MDS) assisterence date (ARI resident with a BIM status) as 15/15. The clinical record summary dated 9/2 the departmental indepartmental indepartmental indepartmental note read "Upon adminiting (morning) medicatifiew times and goes 86%. V/S (vital sign 157/105, P (pulse) (temperature) 98.5 and hands. Notifier practitioner). State hospital emergence (evaluation). Called 33. resign nonrespon	ent in the clinical record what rided to the receiving provider f Resident #72 was reviewed 1/19. Resident #72 was ty 3/8/16 and readmitted ses that included but not knee amputation, acute e, chronic obstructive insomnia, psoriasis,	F	622			
	absent) to neephe		CD5211	F	Facility ID: VA0102	If continuation	sheet Page 23 of 8

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	VILIAL OF TIESCHIST	AMDIOAID OFFICE				OMB I	<u>10. 0938-0391</u>
CENTERS FOR MEDICARE & MEDICAID SERVICES		(X2) MUL	TIDI E CO		TE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION		MPLETED
		495259	B. WNG				3/21/2019
NAME OF P	ROVIDER OR SUPPLIER			ı	ET ADDRESS, CITY, STATE, ZIP COD SLATE CREEK ROAD	E	
HERITAG	E HALL GRUNDY			1	JNDY, VA 24614		
(X4) ID PREFIX TAG	/FACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
F 622	upon departure. No given. Res is own F Attempted to notify 2 Notified niece-she si town for a few days, anything." The departmental naread "Resident admorare unit) with dx (dand resp (respirator). The surveyor was used transfer/discharge for pertinent information when transported to the surveyor requested plan, September profor transfers/discharge for the folia. The reason for the transfer or discharge for dischar	tified ER and gave report RP (responsible person). And contact without success. Itated her mother is out of to contact her if needed on the dated 9/20/18 at 9:58 a.m. itted to hospital ICU (intensive iagnosis) of acute hypoxemia y) distress." Inable to locate form or documentation of the sent with Resident #72 to the hospital on 9/20/18. Indeed the administrator, director corporate registered nurse of on 3/20/19 at 4:18 p.m. The of the face sheet, MDS, care for some some some some some some some some	F	622			

and submit an appeal form; and

(2) information about how to obtain, complete

requests;

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l''	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B. WNG		03/	21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(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 APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	(3) how to get as appeal process; e. The facility bed-hol. No further information exit conference on 3/5. The facility staff fawith the required pap #110's medical inform. Resident #110 was a 2/6/19 with the follow limited to anemia, her pressure, pneumonia MDS (Minimum Data (Assessment Referer resident was coded a long-term memory primoderately impaired Resident #110 was a extensive assistance dressing, personal hydrogen by the facility provided to the facility provided to the facility provided to medications. Since the hospital on 2/9/19, the offer the bed hold por representative. The director of nursimotified of the above 3/20/19 at 3:55 pm.	d policy; In was provided prior to the 21/19. Illed to provide the hospital er work concerning Resident nation. Idmitted to the facility on ing diagnoses of, but not art failure, high blood and dementia. On the Set) with an ARD nec Date) of 2/9/19, the is having short term and oblems and being in daily decision-making. Iso coded as requiring of 2 staff members for regiene and bathing. Ford review on 3/20/18, the Resident #110 had been spital on 2/9/19. The nd any documentation that to the hospital concerning the ndition and/or list of he resident expired at the e facility was not required to licy in writing to the resident's and social worker was documented findings on The social worker stated, paperwork with the resident	F 62	22		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION UM (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495259	B. WNG _			03/2	1/2019
	ROVIDER OR SUPPLIER	I		2966	EET ADDRESS, CITY, STATE, ZIP CODE S SLATE CREEK ROAD UNDY, VA 24614		
(X4) ID PREFIX TAG	/FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 622	Continued From pag	e 25	F	322			
F 623 SS=E	surveyor prior to the Notice Requirements CFR(s): 483.15(c)(3) Notice Before a facility transresident, the facility (i) Notify the resident representative(s) of the reasons for the reasons f	e before transfer. sfers or discharges a must- t and the resident's the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a e Office of the State inbudsman. ons for the transfer or ident's medical record in ragraph (c)(2) of this section; otice the items described in this section. In g of the notice. In the notice of transfer or under this section must be in at least 30 days before the ined or discharged. In made as soon as practicable	F	623	Corrective Action(s): Resident #2's responsible party has notified that the facility failed to prodischarge/transfer notice, failed to prodischarge/transfer notice, failed to probability a statement of the resident's appeal failed to provide information on hot obtain an appeal form and assistance completion of such to the resident's transfer to the hospital on 2/26/19 a facility failed to document in the more cord the Ombudsman notification discharge. Resident #44's responsible party has notified that the facility failed to provide information on hot obtain an appeal form and assistance completion of such to the resident's appeal failed to provide information on hot obtain an appeal form and assistance completion of such to the resident's transfer to the hospital on 12/31/18 the facility failed to document in the medical record the Ombudsman notification of the discharge Resident #46's responsible party has notified that the facility failed to provide information on hotified that the facility failed to provide information on the discharge/transfer notice, failed to provide information on hotified that the facility failed to provide information on the discharge/transfer notice, failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed to provide information on hotified that the facility failed t	ovide a provide rights, we to e in and the edical of the rights, we to be in and the standard recovide a provide a p	

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		COMPLETED					
		495259	B. WING		**************************************	03/:	21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			29	TREET ADDRESS, CITY, STATE, ZIP CODE 966 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 623	allow a more immedia under paragraph (c)((D) An immediate tra required by the residunder paragraph (c)((E) A resident has no days. §483.15(c)(5) Conternotice specified in paragraph (c)((i) The reason for tra (ii) The effective date (iii) The location to wit transferred or discharicity A statement of the including the name, and telephone number receives such request to obtain an appeal for completing the formal hearing request; (v) The name, addrest elephone number of Long-Term Care Om (vi) For nursing facility and developmental disabilities, the mailir telephone number of the protection and acceptable developmental disabilities of the Developmer and Bill of Rights Act codified at 42 U.S.C. (vii) For nursing facility disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand address and telephale and developmental disorder or related dispand	ate transfer or discharge, 1)(i)(B) of this section; nsfer or discharge is ent's urgent medical needs, 1)(i)(A) of this section; or it resided in the facility for 30 ats of the notice. The written uragraph (c)(3) of this section owing: unsfer or discharge; of transfer or discharge; hich the resident is urged; er resident's appeal rights, address (mailing and email), er of the entity which ests; and information on how form and assistance in and submitting the appeal ess (mailing and email) and the Office of the State budsman; by residents with intellectual disabilities or related ong and email address and of the agency responsible for divocacy of individuals with utal Disabilities Assistance of 2000 (Pub. L. 106-402,	F	623	Resident #72's responsible party has be notified that the facility failed to provide discharge/transfer notice, failed to provide a statement of the resident's appeal rig failed to provide information on how to obtain an appeal form and assistance in completion of such to the resident and Responsible party for the resident's transfer to the hospital on 9/20/18 and facility failed to document in the media record the Ombudsman notification of discharge. Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director we conduct a 100% audit of all residents we have been discharged and/or transferred in the past 30 days. Residents identified risk will be corrected at time of discoveryand the required notifications the residents' responsible party and the state ombudsman will be made. A facili Incident & Accident Form will be completed for each negative finding. Systemic Change(s): Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant willinservice the facility's social worker(s), nursing administration and licensed staff on the discharge and transfer requirements that are to be given to the resident and resident's responsible party and that the state ombudsman will be notified of resident discharges/transfers.	de a ide hts, o the	

Facility ID: VA0102

Event ID; CD5211

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495259	B. WING _			03/	21/2019
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGI	E HALL GRUNDY				S SLATE CREEK ROAD		
TILIGIA (A)				GRI	UNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE
F 623	advocacy of individual established under the for Mentally III Individual S483.15(c)(6) Chang If the information in the effecting the transfer must update the recipal as practicable once the becomes available. §483.15(c)(8) Notice In the case of facility the administrator of the written notification proto the State Survey A State Long-Term Carthe facility, and the rewell as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the relocation of the residual as the plan for the location of the residual as the plan for the location of the residual as the plan for the location to which discharged; a statem rights, including the remail), and telephone completing the formal the email of the plan for the remail of the	als with a mental disorder e Protection and Advocacy fuals Act. es to the notice. The notice changes prior to or discharge, the facility poients of the notice as soon the updated information in advance of facility closure closure, the individual who is the facility must provide it in the impending closure agency, the Office of the re Ombudsman, residents of resident representatives, as the transfer and adequate dents, as required at § It is not met as evidenced when, facility document review the facility staff failed the of transfer/discharge to date of transfer or discharge; the resident is transferred or the tent of the resident's appeal thame, address (mailing and the number of the entity which ests; and information on how form and assistance in and submitting the appeal name, address (mailing and the number of the Office of the	F	23	Monitoring: The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions. Director will conduct chart audits were of all residents who have been dischart and/or transferred from the facility. Any/all negative findings and or errors will be corrected at time of discovery disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendation for change in facility policy, procedure and/or practice. Completion Date: 5/5/19	kly ged s and	

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CI

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION (X3) DATE SI			E SURVEY	
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION		APLETED
		495259	B. WING			0:	3/21/2019
	OVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 623	residents (Resident # #46, and Resident # The findings included 1. The facility staff far of transfer to the resident's appear information on how assistance in complete document in the menotification when Resident's appear information on how assistance in complete document in the menotification when Resident when the hospital. The clinical record of 3/19/19 through 3/2 admitted to the facility 2/26/19. Diagnoses acute cellulitis right right great toe, prodisease, diabetes in esophageal reflux, convulsions, anxiet disturbances, hyper Alzheimer's disease. Resident #2's quark with an assessment 12/11/18 assessed memory problems, and severely impair decision-making. The departmental read "LE (late entry to transport res (resident #2).	#2, Resident #44, Resident #72). d: alled to provide written notice ident and the resident to the resident was transferred to provide a statement of all rights, failed to provide to obtain an appeal form and etion of such and failed to dical record ombudsman esident #2 was transferred to of Resident #2 was reviewed 1/19. Resident #2 was reviewed 1/19. Resident #2 was ity 10/11/12 and readmitted included but not limited to foot with infected ulceration of pable peripheral vascular mellitus type II, atrial fibrillation, hypertension, dysphagia, y, dementia without behavioral	F	623			
	1 2				Facility ID: VA0102	If continuation	sheet Page 29 of 8

NAME OF PREFIX TAG	F DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E HALL GRUNDY	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495259	1	NG	CONSTRUCTION	(X3) DATE : COMPI	
(X4) ID PREFIX TAG	HALL GRUNDY	495259	B. WING			i i	
(X4) ID PREFIX TAG	HALL GRUNDY					03/2	21/2019
(X4) ID PREFIX TAG	HALL GRUNDY				REET ADDRESS, CITY, STATE, ZIP CODE		
PREFIX TAG	HERITAGE HALL GRUNDY SUMMARY STATEMENT OF DEFICIENCIES			1	66 SLATE CREEK ROAD RUNDY, VA 24614		
	(FACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 623	Continued From page 29 (medical doctor) wants res (resident) sent to (name of hospital omitted) for direct admit due to cellulitis of Rt. (right) leg. Called for transport and hospital was notified."		F	623			
	Information in Resid The surveyor spoke nurse on 3/20/19 at was sent to the hosy transferred. The coworker completes the social worker. I what information was the resident was ad 2/26/19. The social a form titled Heritage Discharge/Transfer understand that I at Heritage Hall Grundreason for the transphysician for direct "Resident in (name Copy mailed to RP 2/28/19." The social information to the was transferred 2/2 Bed hold acceptant bottom of the page.	Form." The form read, "I m being discharged from dy. I understand that the sfer is recommendation of admission to hospital. of hospital omitted) 2/27/19. (responsible party) on all worker stated he provided the hospital when Resident #2 6/19. ce/declination located at the was blank.					
	done. The surveyor on transfers/discha	nsfer/discharge report was not or requested the facility policy arges. itled "Transfer or Discharge rt "3. The resident and/or			Facility ID: VA0102	If continuation st	2000 200

CENTERS FOR MEDICARE & MEDICAID SERVICES							<u>10. 0938-0391</u>
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495259	B. WING				3/21/2019
NAME OF PR	OVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE	HALL GRUNDY				966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(XS) COMPLETION DATE
F 623	resident representation writing of the followa. The reason for the both the effective date of the location to we transferred or disched. A statement of the transfer or disched. A statement of the transfer or disched. (1) the name, and number of the entity requests; (2) information and submit an appearance of the entity requests; (3) how to get appeal process; e. The facility bed-from the transfer of nursing, nurse of the above. No further informate exit conference on the representative where the thospital, failther resident's appearance in complete the motification when the surveyor information on how assistance in complete the resident of the motification when the surveyor information on how assistance in complete the motification when the surveyor information on how assistance in complete the surveyor information in the surveyor inform	tive (sponsor) will be notified bying information: e transfer or discharge e of the transfer or discharge hich the information is being arged e resident's rights to appeal harge, including; address, email and telephone which receives such about how to obtain, complete eal form; and assistance completing the hold policy; med the administrator, the and the corporate registered information on 3/21/19. sion was provided prior to the	F	623			
	3/19/19 through 3/	of Resident #44 was reviewed 121/19. Resident #44 was bility 9/23/09, readmitted 19 with diagnoses that included			Facility ID: VA0102	W continuation	n sheet Page 31 of 88

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	RIPLE CONSTRUCTION		TE SURVEY MPLETED
		495259	B. WING			03/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP (2966 SLATE CREEK ROAD GRUNDY, VA 24614	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 623	but not limited to he infarction affecting! hepatomegaly, dyspreflux disease, arthout the new onset type multifocal pneumon secondary to volum hyperlipidemia, urin methicillin sensitive and history of seizu Resident #44's 30-assessment with an (ARD) of 2/3/19 assinterview for mental The clinical record dated 12/31/18 that vomited a large amto nurse practitione be transferred to the 12/31/18 read "Transferred to	miplegia following cerebral eft non-dominant side, chagia, gastro-esophageal cpathy, diabetic ketoacidosis a 1 diabetes, sepsis due to dia, acute renal failure de depletion, hypertension, diary tract infection with Staph aureus, hyponatremia, dre disorder. day minimum data set (MDS) on assessment reference date desessed the resident with a brief	F	623		

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
STATEMENT C	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B. WING			03/2	1/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			2	TREET ADDRESS, CITY, STATE, ZIP CODE 966 SLATE CREEK ROAD BRUNDY, VA 24614	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	transfer/discharges. The facility policy til Notice" read in part resident representa in writing of the folic a. The reason for the the transferred or disched. A statement of the the transfer or disched. A statement of the entit requests; (2) information and submit an appeal process; (2) information and submit an appeal process; e. The facility bed-No further informate exit conference on 3. The facility staff of transfer to the representative where the hospital, fail the resident's apprinformation on how assistance in complete document in the motification when the hospital. The clinical record 3/19/19 through 3 admitted to the fail	elled "Transfer or Discharge "3. The resident and/or tive (sponsor) will be notified owing information: ne transfer or discharge e of the transfer or discharge which the information is being narged ne resident's rights to appeal charge, including; address, email and telephone by which receives such about how to obtain, complete eal form; and assistance completing the chold policy; tion was provided prior to the	F	623	RECEIVED APR 2 5 2019 VDH/OLC		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495259	B. WING		0	3/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 623	non-displaced fracturifibula, non-traumatic constipation, gastroes hypertension, Vitamir benign prostatic hypertype 2, chronic hepatianemia. Resident #46's significata set (MDS) assess reference date (ARD) resident with a BIMS status) as 15/15. The surveyor intervier 3/20/19. When asked falls, Resident #46 ra his ankle, and stated broke his ankle. The surveyor reviewed dated 1/24/19 at 12:00 (late entry) from 0900 walkin (sic) down hall walking outside and sout I'm okay." Assess to RT (right) ankle. Ir and FNP (family nurs and gave order for xoutside walking due to notified and res is own The 1/24/19 6:06 p.m. "Late entry for 1700 (x-rays and gave order (emergency room) for (at0 1712 (5:12 p.m.) services here @ this	e of lateral malleolus right subdural hemorrhage, sophageal reflux disease, a deficiency, convulsions, implasia, diabetes mellitus distis, dry eye syndrome, and cant change in minimum issment with an assessment of 2/6/19 assessed the (brief interview for mental difference) wed Resident #46 on difference dif	F6	23		

PRINTED: 04/11/2019 FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION

		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	SURVEY LETED		
STATEMENT OF	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	l i	G	COMP	OOM ELLILO		
		495259	B. WING _		03/	21/2019		
	OVIDER OR SUPPLIER	770200		STREET ADDRESS, CITY, STATE, ZIP COL	DE			
NAME OF PR	OVIDER OR SOFFEIER			2966 SLATE CREEK ROAD				
HERITAGE	HALL GRUNDY			GRUNDY, VA 24614		1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	IN SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 623	Continued From pag	e 34	F	523				
		an and dry upon departure		W. Control of the Con				
	and no visible signs of distress noted.							
		ble te legato dogumentation						
	The surveyor was ur	nable to locate documentation						
	in the clinical record of the above information when Resident #46 was transferred there on							
	1/24/19.	Wido California and a second						
The num								
	The surveyor inform	ed the corporate registered						
	nurse of the above	concern on 3/20/19 at 2:01						
	p.m. and asked whe	ere the information was						
	located when the re	sident was sent to the						
	emergency room.	The corporate RN stated the not been started yet. The						
	transier ionns nau i	the facility policy on						
	transfers/discharge							
	The facility policy til	tled "Transfer or Discharge						
	Notice" read in part	"3. The resident and/or						
	resident representa	tive (sponsor) will be notified						
	in writing of the follo	owing information:						
	a. The reason for the	ne transfer or discharge te of the transfer or discharge				1		
	p. The ellective dat	which the information is being						
	transferred or disch	narged						
	d A statement of the	ne resident's rights to appeal						
	the transfer or disc	harge, including;						
	(1) the name,	address, email and telephone						
	number of the entit	ty which receives such						
	requests;							
	(2) information	about how to obtain, complete						
	and submit an app	eal form; and						
		assistance completing the						
	appeal process; e. The facility bed-	hold policy:						
	e. The facility bed-	Tiota policy,						
	No further informa	tion was provided prior to the						
	exit conference or	3/21/19.						
	JAN 0011101 01							
		Front ID:		Facility ID: VA0102	If continuation :	sheet Page 3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495259	B. WING		03/2	1/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL GRUNDY		25	TREET ADDRESS, CITY, STATE, ZIP CODE 966 SLATE CREEK ROAD RUNDY, VA 24614		
PREFIX (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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
of transfer to the resi representative when to the hospital, failed the resident's appeal information on how to assistance in complet document in the medication when Rest the hospital. The clinical record of 3/19/19 through 3/21 admitted to the facilities 9/24/18 with diagnost limited to above the diastolic heart failure pulmonary disease, gastro-esophageal in hypothyroidism, Vita muscle weakness, of varicose veins of left diabetes mellitus, and Resident #72's significate data set (MDS) assereference date (ARE resident with a BIMS status) as 15/15. The clinical record resummary dated 9/24 the departmental not edicated "Upon administic (morning) medication few times and goes 86%. V/S (vital signification few times and goes 86%.	ailed to provide written notice dent and the resident the resident was transferred to provide a statement of rights, failed to provide o obtain an appeal form and etion of such and failed to dical record ombudsman sident #72 was transferred to f Resident #72 was reviewed 1/19. Resident #72 was that included but not knee amputation, acute e, chronic obstructive insomnia, psoriasis, eflux disease, min deficiency, anemia, besity, hypertension, t lower extremity, type 2	F 623			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495259	B. WING_		(3/21/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETION DATE
F 623	and hands. Notified practitioner). Stated hospital emergency revaluation). Called 33, res nonresponsive absent) to hospital at upon departure. Notigiven. Res is own RI Attempted to notify 21 Notified niece-she statown for a few days, the anything." The departmental nor read "Resident admit care unit) with dx (dia and resp (respiratory). The surveyor was untransfer/discharge for pertinent information transported to the homogeneous transfers/discharge for the above concern of surveyor requested the plan, September programmer of the facility policy title Notice" read in part "resident representation writing of the follow a. The reason for the b. The effective date	Edema noted to face/eyes FNP (family nurse to send res to (name of com omitted) for eval 911. Upon arrival of Rescue e. Res LOA (leave of 0525, res clean and dry fied ER and gave report P (responsible person). Ind contact without success. Interested her mother is out of to contact her if needed te dated 9/20/18 at 9:58 a.m. Ited to hospital ICU (intensive legnosis) of acute hypoxemia I) distress." able to locate Im or documentation of when Resident #72 was spital on 9/20/18. Indet the administrator, director corporate registered nurse of in 3/20/19 at 4:18 p.m. The ine face sheet, MDS, care gress notes and the policy les. Indet "Transfer or Discharge 3. The resident and/or ive (sponsor) will be notified wing information: It transfer or discharge of the transfer or discharge of the transfer or discharge of the transfer or discharge ich the information is being	F	523		

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		Sonomou	(X3) DATE SURVEY COMPLETED	
		495259	B. WING_			03/2	1/2019
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 2966 SLATE CREEK ROAD GRUNDY, VA 24614			DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 625 SS=E	the transfer or discha (1) the name, ac number of the entity requests; (2) information a and submit an appea (3) how to get a appeal process; e. The facility bed-hold for the facility bed-hold for the facility bed-hold for the facility frans the resident goes or nursing facility trans the resident or resid specifies-(i) The duration of the facility; (ii) The reserve bed plan, under § 447.4 (iii) The nursing facility, where the facility; (iii) The nursing facility is the resident or the resident or the facility; (iii) The reserve bed plan, under § 447.4 (iiii) The nursing facility is the resident of the facility; (iii) The reserve bed plan, under § 447.4 (iiii) The nursing facility is the facil	resident's rights to appeal arge, including; ddress, email and telephone which receives such about how to obtain, complete al form; and assistance completing the old policy; and was provided prior to the /21/19. Policy Before/Upon Trnsfr (2) f bed-hold policy and returnation to a therapeutic leave, the provide written information to ent representative that the state bed-hold policy, if he resident is permitted to esidence in the nursing payment policy in the state of this chapter, if any; lity's policies regarding hich must be consistent with this section, permitting a		625	F625 Corrective Action(s): Residents #2, #44, #46, #72, #86and their have been notified of the facilities bed-hopolicy and procedure and the requirement reviewed and issued in writing to the resi and the RP when discharge to the hospita when going out on therapeutic leave. An Incident and Accident form has been comfor each resident identified in the review. Identification of Deficient Practice(s) at Corrective Action(s): All other residents could potentially be at The Bed-Hold policy and forms are now the nursing station for after hour's transfet the hospital to be completed by the charge nurse. The Social Services director/Adm director will be responsible for normal behour transfer notification of all bed-holds residents and/or Responsible parties. Systemic Change(s): The facility Policy and Procedure has be reviewed and no changes are warranted time. The Social Services Director, Adm Director and licensed staff have been	old t that it ident id or inpleted ind ffected. kept at ers to ge issions usiness s to een at this	
	§483.15(d)(2) Bed-l	nold notice upon transfer. At			inservicedby the administrator on the be	d-hold	

/EC//17 11	MENT OF HEALTH AN	MEDICAID SERVICES				OMB NO.	
ATEMENT O	FOR MEDICARE & I F DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	•	495259	B. WING			03/2	/2019
AME OF P	ROVIDER OR SUPPLIER			1	REET ADDRESS, CITY, STATE, ZIP CODE		
				1	66 SLATE CREEK ROAD		
IERITAGE	HALL GRUNDY			G	RUNDY, VA 24614		
(X4) ID PREFIX TAG	/EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE RIATE	(X5) COMPLETION DATE
	Continued From pag the time of transfer of hospitalization or the facility must provide resident representatis specifies the duration described in paragra. This REQUIREMEN by: Based on staff inter and clinical record reto provide to the res representative at the written notice which bed-hold policy for Resident #44, Resident #86). The findings included 1. The facility staff and the resident repinformation about be was transferred to the transferred to the standard policy for the clinical record 3/19/19 through 3/2 admitted to the facility staff and the resident repinformation about be was transferred to the standard policy for the clinical record 3/19/19 through 3/2 admitted to the facility staff and the resident region admitted to the facility staff and the resident region admitted to the facility staff and the resident region at	e 38 f a resident for rapeutic leave, a nursing to the resident and the ve written notice which n of the bed-hold policy ph (d)(1) of this section. T is not met as evidenced view, facility document review eview, the facility staff failed ident and the resident e time of transfer/discharge specifies the duration of the fof 26 residents (Resident #2, dent #46, Resident #72, and ed: failed to provide Resident #2 presentative written ed-hold when the resident the hospital 2/26/19. of Resident #2 was reviewed e1/19. Resident #2 was lity 10/11/12 and readmitted is included but not limited to foot with infected ulceration of pable peripheral vascular mellitus type II, atrial fibrillation, hypertension, dysphagia,		625	requirement and the proper use and no of the Bed-Hold policy. Monitoring: The Admissions Director and Social S Director are responsible for compliance transfers/discharges from the facility waudited the by the Social service direct Admissions Director to ensure proper notification was completed at the time or therapeutic leave. Any/all negative will be corrected at time of discovery. results of these audits will be forward Quality Assurance Committee quarter review, analysis, and recommendation change in facility policy, procedure, a practice. Completion Date: 5/5/19	ervice e. All vill be tor and/or bed-hold of transfer findings The ed to the ely for as for	
	convulsions, anxiety, dementia without behavioral disturbances, hyperlipidemia, anemia, Alzheimer's disease, and seizure disorder. Resident #2's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/11/18 assessed the resident with short-term						
	12/11/18 assessed	5	ND6244		Facility ID: VA0102	continuation sh	et Page 39

	S FOR MILDIOARL &	I	C/2) MI II T	TIPLE CONSTRUCTION		TE SURVEY		
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NG	CO	COMPLETED		
		495259	B. WNG_			3/21/2019		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2966 SLATE CREEK ROAD GRUNDY, VA 24614	DE			
(X4) ID PREFIX TAG	/FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	1 00000 NEEEDENICED TO 11	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE		
F 625	memory problems, leand severely impaired decision-making. The departmental neread "LE (late entry) to transport res (resomitted). Informed (medical doctor) wa (name of hospital or cellulitis of Rt. (right hospital was notified. The clinical record of that written notice or provided to the resire representative whe to the hospital 2/26. The surveyor spoken urse on 3/20/19 a was sent to the hospital 2/26. The surveyor spoken urse on 3/20/19 a was sent to the hospital 2/26. The surveyor spoken urse on 3/20/19 a was sent to the hospital 2/26. The surveyor spoken urse on 3/20/19 a was sent to the hospital 2/26. The surveyor spoken urse on 3/20/19 a was sent to the hospital 2/26. The surveyor spoken urse on 3/20/19 a was sent to the hospital 2/26/19. The social form titled "Heritate Understand that I a Heritage Hall Grur reason for the transphysician for direct Resident in (name Copy mailed to Rf 2/28/19." The social of the properties of the properties of the transphysician for direct Resident in (name Copy mailed to Rf 2/28/19." The social of the properties of the properti	ong-term memory problems, and cognitive skills for daily onte dated 2/26/19 at 2:34 p.m. I from 0900: Rescue 33 here ident) to (name of hospital by night shift nurse that MD ints res (resident) sent to mitted) for direct admit due to o) leg. Called for transport and di." did not have documentation of bed hold information was dent and the resident in Resident #2 was transferred /19. The with the corporate registered at 10:24 a.m. what information is opital when residents are or porate RN stated the social that. The surveyor interviewed The social worker was asked has sent with the resident when dimitted to the hospital on all worker provided the surveyor age Hall Grundy in Form." The form read, "I am being discharged from holy. I understand that the insfer is recommendation of it admission to hospital. To (responsible party) on cial worker stated he provided the hospital when Resident #2	F	625				
	was transferred 2	26/19.	 D5211	Facility ID: VA0102	If continuation	n sheet Page 40 of		

PRINTED: 04/11/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B. WING		03/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP 2966 SLATE CREEK ROAD GRUNDY, VA 24614	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1 00000 000000NOCO TO	THE APPROPRIATE COMPLETION DATE
F 625	Continued From pag	e 40	F	625	
	Bed hold acceptance bottom of the page w	e/declination located at the vas blank.			
	director of nursing, a nurse of the above of	ed the administrator, the and the corporate registered concern on 3/20/19 at 3:50 the facility policy on bed hold.			
	"Bed-Holds and Retored in part "Prior to leaves, residents or	red the facility policy titled urns" on 3/21/19. The policy transfers and therapeutic resident representatives will g of the bed-hold and return			
	No further information exit conference on 3	on was provided prior to the 3/21/19.			
	and the resident rep information about be was transferred to the	ed-holds when the resident he hospital 12/31/18.			
	3/19/19 through 3/2 admitted to the facil 11/29/16 and 1/5/19 but not limited to he infarction affecting	of Resident #44 was reviewed 1/1/9. Resident #44 was lity 9/23/09, readmitted 9 with diagnoses that included emiplegia following cerebral left non-dominant side, phagia, gastro-esophageal			
	reflux disease, arth with new onset type multifocal pneumor secondary to volum hyperlipidemia, urir	opathy, diabetic ketoacidosis 1 diabetes, sepsis due to nia, acute renal failure ne depletion, hypertension, nary tract infection with 2 Staph aureus, hyponatremia,	And the second s		

FORM APPROVED

		INEDICAID SERVICES	V2) MH.	CIDI E	CONSTRUCTION	(X3) DATE SURVEY		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			COMPLE	ETED	
		40roro	B. WING			03/2	1/2019	
	- 40 CO ON 1001 150	495259	B. WING	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 00.2		
NAME OF PI	ROVIDER OR SUPPLIER			l	966 SLATE CREEK ROAD			
HERITAGI	E HALL GRUNDY			G	RUNDY, VA 24614			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 625	assessment with an (ARD) of 2/3/19 asses interview for mental interview interv	asyminimum data set (MDS) assessment reference date essed the resident with a brief status as 15/15. Everaled a departmental note read in part Resident #44 bunt of brown substance. Call who ordered the resident to a hospital. The order dated sfer to (name of ency room) for eval estion, N/V (nausea/vomiting) It pressure) 130/76, T P (pulse) 110, 94%." Idid not have documentation for bed hold information was dent and the resident in Resident #44 was ospital 12/31/18. In Resident #44 was ospital 12/31/18. In Resident #44's face alan, December 2018 alan, December 2018 alan, December 2018 alan, December 2019 departmental hold policy. Wed the facility policy titled of transfers and therapeutic resident representatives willing of the bed-hold and return	F	625				
	No further informat exit conference on	ion was provided prior to the 3/21/19.						

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	COMPLETED		
		495259	B. WING			03/2	1/2019	
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 966 SLATE CREEK ROAD RUNDY, VA 24614			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE į	(X5) COMPLETION DATE	
F 625	Continued From page	e 42	F	625				
	and the resident repr	d-hold when the resident						
	3/19/19 through 3/21 admitted to the facilit 9/21/07 with diagnos non-displaced fractu fibula, non-traumatic constipation, gastros hypertension, Vitami benign prostatic hyp	f Resident #46 was reviewed /19. Resident #46 was ty 6/27/17 and readmitted les that included re of lateral malleolus right esophageal reflux disease, in deficiency, convulsions, erplasia, diabetes mellitus titis, dry eye syndrome, and						
	data set (MDS) asser	ficant change in minimum essment with an assessment o) of 2/6/19 assessed the 6 (brief interview for mental	A A A A A A A A A A A A A A A A A A A					
	3/20/19. When asked falls, Resident #46 r	ewed Resident #46 on ed if the resident had any aised his right leg, pointed to d he slipped in the snow and						
	dated 1/24/19 at 12 (late entry) from 090 walkin (sic) down haw walking outside and but I'm okay. Asset to RT (right) ankle. and FNP (family nu	ved the departmental note: 00 p.m. The note read "LE 00: Res (resident) came all to nurse and stated "I was I slipped and hurt my ankle esment reveals swollen area Instructed res to elevate leg rse practitioner) was notified x-ray. Instructed rest to not be						

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED			
		495259	B. WING			03/	21/2019
	ROVIDER OR SUPPLIER HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 625	notified and res is own The 1/24/19 6:06 p.m "Late entry for 1700 of x-rays and gave order (emergency room) for (at) 1712 (5:12 p.m.) services here @ this (name of hospital ER report. Resident clear and no visible signs. The clinical record did that written notice of provided to the resid representative when transferred to the horomorphism of the above of p.m. and asked about corporate registered worker completes the the social worker. To information about be #46. The surveyor informed incompanies of the above of p.m. and requested. The surveyor review "Bed-Holds and Reteread in part "Prior to leaves, residents or	to inclement weather. FNP on RP (responsible party)." In. departmental note read (5:00 p.m.) FNP notified of ears to send resident to ER or further eval (evaluation). @ Rescue 33 ambulance time to transport resident to R) omitted. ER staff given an and dry upon departure of distress noted." Id not have documentation bed hold information was ent and the resident Resident #46 was spital 1/24/19. Bed the corporate registered oncern on 3/20/19 at 2:01 at bed-hold information. The nurse stated the social at. The surveyor interviewed the social worker did not have ad hold policy for Resident ed the administrator, the land the corporate registered concern on 3/20/19 at 3:50	F	625			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l l	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495259	B. WING			03/2	1/2019
	ROVIDER OR SUPPLIER	1		2	STREET ADDRESS, CITY, STATE, ZIP CODE 1966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	B€	(X5) COMPLETION DATE
F 625	Continued From pag	e 44	F	625			
	No further informatio exit conference on 3	n was provided prior to the 21/19.					
	and the resident repr	d-hold when the resident				is the state of th	
	The clinical record o 3/19/19 through 3/21 admitted to the facili 9/24/18 with diagnos limited to above the diastolic heart failure pulmonary disease, gastro-esophageal rhypothyroidism, Vitamuscle weakness, o	f Resident #72 was reviewed 1/19. Resident #72 was 1y 3/8/16 and readmitted 1/19. Resident #72 was 1y 3/8/16 and readmitted 1/19. Resident #72 was 1/19. In the set that included but not 1/19. In the set that inclu					
	data set (MDS) asser	ficant change in minimum essment with an assessment O) of 2/25/19 assessed the S (brief interview for mental					
	summary dated 9/24 the departmental note of read "Upon adminis (morning) medication few times and goes 86%. V/S (vital sign 157/105, P (pulse) (temperature) 98.5.	evealed a discharge 4/18. The surveyor reviewed stes for September 2018. The lated 9/20/18 at 8:23 a.m. tering res (resident) am on, res lethargic, opens eyes a back to sleep. O2 (oxygen) ns): BP (blood pressure) 86, R (respirations) 20, T Edema noted to face/eyes					

CENTERS FOR MEDICARE & MEDICAID SERVICES

	FOR MEDICARE & DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	IPLE CO	DNSTRUCTION		TE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			
	-	495259	B. WING			0	3/21/2019
NAME OF PR	OVIDER OR SUPPLIER	1,000			EET ADDRESS, CITY, STATE, ZIP CODE		
	HALL GRUNDY		!		S SLATE CREEK ROAD UNDY, VA 24614		
HEIGHAGE					PROVIDER'S PLAN OF COR	RECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDESICIENCY)	SHOULD BE	COMPLETION DATE
F 625	hospital emergency (evaluation). Called 33, res nonresponsivabsent) to hospital a upon departure. No given. Res is own F Attempted to notify 2 Notified niece-she s town for a few days, anything." The departmental n read "Resident admicare unit) with dx (dand resp (respirator). The clinical record that written notice oprovided to the resi representative when transferred to the homogeneous of the above p.m. and requested. The surveyor revien "Bed-Holds and Registed in part "Prior leaves, residents of be informed in writt policy." No further informat exit conference or 5. The facility states.	to send res to (name of room omitted) for eval 911. Upon arrival of Rescue ve. Res LOA (leave of the 0525, res clean and dry stiffied ER and gave report RP (responsible person). 2nd contact without success. tated her mother is out of the contact her if needed note dated 9/20/18 at 9:58 a.m. witted to hospital ICU (intensive liagnosis) of acute hypoxemia ry) distress." did not have documentation of bed hold information was ident and the resident m Resident #72 was cospital 9/20/18. med the administrator, the and the corporate registered concern on 3/20/19 at 3:50 d the bed hold policy. weed the facility policy titled enturns" on 3/21/19. The policy to transfers and therapeutic or resident representatives will ting of the bed-hold and return tion was provided prior to the 13/21/19. If failed to provide the bed hold	F	625			
	policy in writing di	ue to Resident #86 being	205344	E.	acility ID: VA0102	If continuatio	n sheet Page 46 of 8

PRINTED: 04/11/2019 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING _ AND PLAN OF CORRECTION 03/21/2019 B. WNG 495259 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2966 SLATE CREEK ROAD HERITAGE HALL GRUNDY **GRUNDY, VA 24614** PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DEFICIENCY) TAG F 625 F 625 Continued From page 46 transferred to emergency room. Resident #86 was originally admitted to the facility on 2/22/19 but was readmitted on 3/13/19. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/1/19, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #86 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing. The surveyor reviewed Resident #86's clinical record on 3/20/19 and 3/21/19. During this review, the surveyor noted that Resident #86 had been transferred to the hospital, on 3/8/19, to receive a blood transfusion. The surveyor could not find documentation in the clinical record of the bed hold policy being given to the resident and/or resident representative in written form. The surveyor requested and received the policy titled "Transfer or Discharge Notice" which read in part, " ... The resident and/or representative (sponsor) will be notified in writing of the following information ... The facility bed hold policy ... " The surveyor notified the administrative team of the above documented findings on 3/20/19 at 3:55 pm in the conference room.

transferred to the hospital."

On 3/21/19 at 9:06 am, the social worker came to the surveyor and stated, "We didn't give the resident the bed hold policy when he was

No further information was provided to the surveyor prior to the exit conference on 3/21/19.

+ **	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495259	B. WING		03/21/2019
•	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614	
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 658 SS=D	S483.21(b)(3) Comprete services provided as outlined by the commust- (i) Meet professional This REQUIREMENT by: Based on staff intervand clinical record reto follow professional transcription of physic medications for 1 of 2 #160). The findings included The facility staff incor Resident #160's labor clinical record. The lorders for antibiotics physician orders were Resident #160 because laboratory test results record. The 1/14/19 been noted by license #1). L.P.N. #1 failed for Resident #160's at The clinical record of reviewed 3/21/19. Reto the facility 12/18/1 diagnoses that includinfarction, hemiplegical effecting left non-dor cardiomegaly, hyperthyperlipidemia, anxiety	ehensive Care Plans of or arranged by the facility, imprehensive care plan, standards of quality. is not met as evidenced iew, facility document review view, the facility staff failed standards of practice for the cian orders involving to residents (Resident trectly filed the results of ratory test on Resident #46's aboratory test had physician for Resident #160. The te never implemented for ties the facility staff filed the ties with orders in the wrong turine culture results had ted practical nurse #1 (L.P.N. It to write a telephone order tintibiotic. Resident #160 was tesident	F 654	Resident #160's attending physician been notified that the facility staff of implement an antibiotic order for reference #160 as ordered by the physician been the facility filed the lab test results the facility filed the lab test results the antibiotic order written on it in wrong medical record. A Facility Incident&Accident Form was comfor these incidents Identification of Deficient Practices/Corrective Action(s): All other residents may have been potentially affected. The DON, All and/or designee will conduct a 100 review of all resident's medication and lab tests to identify any residents. All residents identified at rist corrected at time of discovery and attending physician will be notified each error. An Incident & Accide will be completed for each negatifinding. Systemic Change(s): The facility policy and procedure been reviewed and no revisions ar warranted at this time. The nursing assessment process as evidenced be 24 Hours Report, documentation is medical record and physician order remains the source document for the development and monitoring of calculations which includes, obtaining, transcril and administering physician order medicationsper physician order. Listaff will be inserviced by the DOI and/or regional nurse consultant or policy & procedure for medication administration to include giving at ordered time and physician notific a medication is held or refused.	did not esident because with the pleted DON 10% or orders ents at a will be at the ent form we has e gry the ent the ers he ere bing ed censed N on the ents at t

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS	FOR MEDICARE &	MEDICAID SERVICES			VONCTORICTION	(X3) DATE SU	JRVEY
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	COMPLE	
		495259	B. WING			03/21	1/2019
HERITAGE (X4) ID	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREF	GF	REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	(X5) COMPLETION DATE
PREFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		
F 658	extremities. Resident #160's 30 ovith an assessment 2/5/19 assessed the memory problems, is and moderately impodecision making-decision makin	day minimum data set (MDS) reference date (ARD) of resident with short term ong term memory problems, aired cognitive skills for cisions poor; needs cues and orders dated 1/10/19 for a UA culture/sensitivity dx ria. ed two results of the urine in Resident #160's clinical and in Resident #46's record had or the nurse practitioner (NP) for grams) q12 (every) x 5 days, noted by L.P.N. #1. The d in Resident #160's laboratory ew orders-NP signature and en the nurse practitioner (NP) unable to locate a telephone foom median to the stelephone form memory problems for the stelephone fo	F	658	Monitoring: The DON is responsible for mainta compliance. The DON and/or ADC review medication orders weekly coinciding with the care plancalend order to maintain compliance. Any negative findings will be corrected of discovery and disciplinary action be taken as needed. Aggregate find of these audits will be reported to the Quality Assurance Committee quastor review, analysis, and recommendations for change in far policy, procedure, and/or practice. Completion Date: 5/5/19	ON will lar in /all at time n will dings he rterly	
<u> </u>	result should be tr	anscribed to a telephone order Sobsolete Event ID: 0	:D5211		Facility ID: VA0102	ontinuation she	et Page 49 of 88

ATEMENT OF	FOR MEDICARE & DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TRUCTION	(X3) DATE S COMPL	
		495259	B. WNG			03/2	1/2019
	OVIDER OR SUPPLIER			2966 SI	TADDRESS, CITY, STATE, ZIP CODE LATE CREEK ROAD DY, VA 24614		
(X4) ID PREFIX TAG	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE ∣	(X5) COMPLETION DATE
F 658	practitioner (FNP) or FNP stated she was Resident #160 did n antibiotic. "You assimedications that I praked about the me reviewing the lab rewanted the resident. The facility policy tit Treatment Orders" administered only uperson duly license such medications in biologicals must be Order Sheet in the are reviewed by the monthly basis. 4. A shall be written, dail lawfully authorized. The facility policy tit Documentation" rethe medical record and accurate." No further informal exit conference on Quality of Care CFR(s): 483.25 § 483.25 Quality of Quality of care is a applies to all treating the medical record and accurate is a applies to all treating the side of the state of the stat	ewed the family nurse in 3/21/19 at 1:00 p.m. The never made aware that of receive the ordered ume the residents get the rescribe." The FNP was dication orders. After sults, the FNP stated she to have the Cipro. Ied "Medication and read, "1.Medications shall be pon the written order of a d and authorized to prescribe in this state. 3. Drugs and recorded on the Physician's resident's chart. Such orders is consultant pharmacist on a full drugs and biological orders ied, and signed by the person to give such an order." Itted "Charting and ad in part "3. Documentation in will be objective, complete, ion was provided prior to the 3/21/19.		658 F 684	F684 Corrective Action(s): Resident #160's attending pleen notified that the facility implement an antibiotic orde #160 as ordered by the phythe facility filed the lab test the antibiotic order written or the facility or the facility order written or the facility or the facility order written or the facility or the facility order written order written or the facility order written or the facility order written or the facil	y staff did not er for resident sician because results with	

PRINTED: 04/11/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1.	ULTIPLE CONSTRUCTION (X3) DATE S LDING			
		495259	B. WING			03//	21/2019
NAME OF P	ROVIDER OR SUPPLIER		•	8	STREET ADDRESS, CITY, STATE, ZIP CODE		
LICOITAG	CHAIL ORINDY			2	966 SLATE CREEK ROAD		
HERITAGI	E HALL GRUNDY			(GRUNDY, VA 24614		
(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 I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 684	that residents receive accordance with profipractice, the compreheare plan, and the restrained practice, the compreheare plan, and the restrained	dent, the facility must ensure treatment and care in essional standards of ensive person-centered sidents' choices. The is not met as evidenced encorrectly filed the results of ratory test on Resident #46's aboratory test had physician for Resident #160. The enever implemented for use the facility staff filed the environment with orders in the wrong entire culture results had end practical nurse #1 (L.P.N. to write a telephone order entibiotic-Cipro 500 mg and 12 hours x 5 days. The receive Cipro for a urinary entire desident #160 was admitted and readmitted 1/7/19 with led but not limited to urinary all infarction, hemiplegia arction affecting left entire the property of the property and the	F	684	wrong medical record. LPN#1 has received disciplinary action and has inserviced by the DON/designee on physician order transcription. A Fac Incident&Accident Form was comp for these incidents. Resident #30's attending physician notified that the facility staff failed administer Atorvastatin and Coreg medicationsas ordered by the physic facility Medication Error form was completed for this incident. Identification of Deficient Practices/Corrective Action(s): All other residents may have potent been affected. The DON, ADON, a Unit Managers will conduct a 100% of all resident's physician medication orders and MAR's to identify residerisk. Residents identified at risk will corrected at time of discovery and that attending physicians will be notified each negative finding and a facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): The facility policy and procedures here reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by 24-Hour Report and documentation medical record /physician orders rethe source document for the develop and monitoring of the provision of which includes, obtaining, transcrib and administering physician orders medications and treatments. The DO and/or Regional nurse consultant winservice all licensed nursing staff of procedure for obtaining, transcribin procedure for obtaining, transcribin	illity leted was to cian. A ially nd caudit on ent at l be heir l of ave the in the mains pment care, ing d DN ill on the	

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

Event ID: CD5211

Facility ID: VA0102

If continuation sheet Page 51 of 88



OCHTED	O COD MEDICADE 8	MEDICAID SERVICES				OWR NO	. 0938-0391
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE : COMPI	
		495259	B. WING			03/2	21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			29	REET ADDRESS, CITY, STATE, ZIP CODE 166 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(FACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	decision making-decision. Resident #160 had of (urinalysis) w (with) (diagnosis) hematur. The surveyor locate culture-one found in record and one four record. The results found in an order written by of Cipro 500 mg (millig dated 1-14-19 and of culture result found section read "No ned dated 1-15-18 (?19) The surveyor was order for the Cipro Resident #160's clip and the policy on dasked if the order for the trained the policy on dasked if the order for the trained the DON state. The surveyor interpractitioner (FNP) FNP stated she was Resident #160 did antibiotic. "You as	orders dated 1/10/19 for a UA culture/sensitivity dx ia. d two results of the urine Resident #160's clinical in Resident #46's clinical in Resident #46's record had the nurse practitioner (NP) for grams) q12 (every) x 5 days, noted by L.P.N. #1. The in Resident #160's laboratory is worders-NP signature and)." unable to locate a telephone 500 mg q12 h x 5 days in nical record. med the director of nursing of on 3/21/19 at 10:19 a.m. The is the facility standard of inscription of physician orders locumentation. The DON was found on the urine culture anscribed to a telephone order	F	684	physician. Licensed staff will also inserviced on the proper use of the emergency/Stat box for administenew or unavailable medications for administration. Monitoring: The DON will be responsible for maintaining compliance. The DO ADON and/or Unit Managers wiperform weekly MAR and chart coinciding with the care plan calmonitor for compliance. Any/all findings and or errors will be contime of discovery and disciplinate will be taken as needed. Aggreg findings of these audits will be rethe Quality Assurance Committed quarterly for review, analysis, as recommendations for change in policy, procedure, and/or practice Completion Date: 5/5/19	be e facility ring or ON, Ill audits endar to negative rected at ry action rate eported to be end facility be.	nest Parie 52

	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTR			TE SURVEY APLETED
		495259	B. WING_		4444	0	3/21/2019
	OVIDER OR SUPPLIER	43333		2966 SLA	DDRESS, CITY, STATE, ZIP CODE TE CREEK ROAD Y, VA 24614		
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES YY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	E	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	reviewing the lab reswanted the resident The facility policy titl Treatment Orders" radministered only uperson duly licensed such medications in biologicals must be Order Sheet in the rare reviewed by the monthly basis. 4. A shall be written, dat lawfully authorized the medical record and accurate." No further informate exit conference on Based on staff intered and facility documentation failed to follow physicians. The findings include the findings included the findings included the follow physician. The clinical record #30 had been re-appliagnoses included the findings included the	dication orders. After sults, the FNP stated she to have the Cipro. ed "Medication and ead, "1. Medications shall be continuously the written order of a diand authorized to prescribe this state. 3. Drugs and recorded on the Physician's resident's chart. Such orders consultant pharmacist on a sulf drugs and biological orders ed, and signed by the person to give such an order." tied "Charting and add in part "3. Documentation in will be objective, complete, from was provided prior to the 3/21/19. rview, clinical record review, ent review, the facility staff sician orders for 2 of 26 nt's #30 and #160. ded: 1. O, the facility staff failed to dications atorvastatin (liptor) reg) as ordered by the	F	684			
	weakness, atrial fi	brillation, hypertension, chronic	05044	Earliity I	ID: VA0102	If continuation	n sheet Page 53 of 8

	COD MEDICADE 9	MEDICAID SERVICES				T	<u>0. 0936-039 i</u>
	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		NSTRUCTION		E SURVEY PLETED
		495259	B. WING			03	3/21/2019
	ROVIDER OR SUPPLIER			2966	ET ADDRESS, CITY, STATE, ZIP CODE SLATE CREEK ROAD INDY, VA 24614		
HERITAGE	HALL GROKE				PROVIDER'S PLAN OF CORRE	CTION	(X5)
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F 684		ge 53 ny disease, hypothyroidism,	F	684			A
	and gastro-esophag	eal reflux disease.					
	annual MDS (minim an ARD (assessme included a BIMS (bi	e patterns) of the Residents num data set) assessment with nt reference date) of 01/17/19 rief interview for mental status) I1 out of a possible 15 points.		And the second s			
	medication adminis the facility nursing s had not administers 40 mg or the Resid	idents eMARs (electronic tration records) revealed that staff had documented that they ed the Residents atorvastatin lents carvedilol 3.125 mg on edications were not available.	Martin Company of the	A STATE OF THE STA			
	list revealed that th	ility stat box/emergency supply se medications would have ne stat box/emergency supply	A CONTRACTOR OF THE CONTRACTOR	THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TO THE PERSON NAMED IN COLUMN T			
	Shortages/Unavail "Upon discovery the supply of a medical Facility staff should obtain the medical medication is not a Medication Supply	procedure titled "Medication lable Medications" read in part, nat Facility has an inadequate ation to administer to a resident, d immediately initiate action to tion from PharmacyIf the available in the Emergency y, Facility staff should notify range for an emergency delivery		And the second s			
	included the problem	CP (comprehensive care plan) lem area at risk for ated to hyperlipidemia ded, but were not limited to, red.					
	The administrativ	e staff were notified of the issue					1 54

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		STRUCTION	(X3) DATE S COMPL	
		495259	B. WING			03/2	21/2019
	ROVIDER OR SUPPLIER			2966 8	ET ADDRESS, CITY, STATE, ZIP CODE BLATE CREEK ROAD NDY, VA 24614	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695 SS=E	regarding the Reside physician ordered made 3:55 PM. No further information provided to the survice conference. Respiratory/Trachet CFR(s): 483.25(i) § 483.25(i) Respirate tracheostomy care and tracheal scare, consistent with practice, the compricare plan, the reside and 483.65 of this strain this REQUIREMENT by: 2. For Resident #7 ensure respiratory Resident #73 was a conference with the most recent Man ARD (assessment and ARD (assessmen	ent not receiving their nedications on 03/20/19 at on regarding this issue was rey team prior to the exit ostomy Care and Suctioning and tracheal suctioning. Issure that a resident who are, including tracheostomy uctioning, is provided such the professional standards of rehensive person-centered lents' goals and preferences,		695	F695 Corrective Action(s): Resident #73's attending physical notified that the facility failed resident #73's Nebulizer mour plastic bag when not in use. A Incident & Accident form has completed for this incident. Resident #23's attending physical notified that the facility failed resident #23'sBiPap mask and in a plastic bag when not in use Incident & Accident form has completed for this incident. Resident #72's attending physical notified that the facility failed resident #72'sBiPap mask, he nebulizer mask in a plastic bain use and the facility failed to oxygen at the physician order Afacility Incident & Accident been completed for this incident. Resident #159's attending physicial notified that the facility failed to oxygen at the physician order Afacility Incident & Accident been completed for this incident. Resident #159's attending physician and failed to state of the physicia	to store th piece in a A facility s been sician was I to store d face gear se. Afacility s been sician was I to store d face gear se. Afacility s been sician was I to store eadgear and ag when not to administer red flow rate. It form has lent. sysician was d to obtain low rate from ore resident lizer mask in and did not	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	(X3) DATE S COMPLI		
		495259	B. WING			03/2	1/2019	
,	PROVIDER OR SUPPLIER	2966 SLATE CI			REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614	REEK ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE j	(X5) COMPLETION DATE	
F 695	(every) 6 hrs" and "Il solution. Take 1 UD On 03/20/19 at approbserved Resident # lying on his nightstar bagged. The surveyor spoke nurse on 03/20/19 a regarding Resident The infection contro surveyor to Resident nurse observed the mouthpiece and star mouthpiece and star mouthpiece should but should be bagged. The surveyor reque policy entitled "Depton Therapy)-Prevention part "Infection Context Medication Nebulized Store the circuit in pand Resident's name. The concern of not nebulizer mouthpie the administrative so 03/20/19 at approximation. The facility staff #23's bipap mask aplastic bag when now then the oxygen to the solution.	pratropium BR 0.02% packet via nebulizer q 6 hrs". oximately 1300, surveyor f73's nebulizer mouthpiece and. The mouthpiece was not with the infection control trapproximately 1325 f73's nebulizer mouthpiece. I nurse accompanied the at's room. The infection control Resident's nebulizer ted to the surveyor that the not be lying on the nightstand, ed. sted and was provided with a partmental (Respiratory of Infection" which read in rol Considerations related to bers/Continuous Aerosol: 7. plastic bag, marked with date ne, between uses". having the Resident's ce bagged was discussed with staff during a meeting on	F	695	Resident #13's attending physician on the delivery of oxygen administration has been receiving oxygen, BiPapaper physician ordered setting improper storage of oxygen/literature discovered. Systemic Change(s): The facility policy and procedure for oxygen administration and monitoring per physician ordered setting inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician ordered setting inserviced on the facility policy and procedure for oxygen administration and monitoring per physician ordered setting inserviced on the facility policy and procedure for oxygen administration and monitoring per physician order. Inservices will incident at the delivery of oxygen per physician order oxygen administration and monitoring per physician order. Inservices will incident the delivery of oxygen per physician order deservices will incident and monitoring of oxygen flow rates during shift and the proper storage or oxygen/nebulizer equipment when no use.	e it was dent cident. es & ap and ally been lents i a DON, atify en ag s and er ats found time of ident n or iewed his be lude a ags s f		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE : COMPL	
		495259	B. WING			03/2	21/2019
	ROVIDER OR SUPPLIER			25	TREET ADDRESS, CITY, STATE, ZIP CODE 966 SLATE CREEK ROAD FRUNDY, VA 24614		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	admitted to the facility included but not limited disease, dysphagia, hinfarct affecting right hypertension, major of hyperlipidemia, anxied disease, hypothyroidid dysarthria and anarth disease, and unspecific Resident #23's quarter (MDS) assessment was reviewed. Problem 15/15. Resident #23's current was reviewed. Problem 15/15.	w 8/17/17 with diagnoses that and to cerebrovascular memiplegia following cerebral mon-dominant side, depressive disorder, ty, gastroesophageal reflux sm, urine retention, ria, aphasia, chronic kidney fied intellectual disabilities. Berly minimum data set with an assessment of 1/14/19 assessed the (brief interview for mental set) of 1/14/19 assessed the (brief interview for mental set) of 1/14/19 assessed the (brief interview for mental set) of 1/14/19 assessed the (brief interview for mental set) on 3/19/19 at 8:57 a.m., the bipap mask and face gear 8's nightstand. Neither one istic bag. The oxygen om was turned off; however, is not dated. The surveyor	F	695	Monitoring: The DON is responsible for maintain compliance. The DON, ADON and/o Unit manager will performdaily audit all residents using oxygen to monitor compliance. All negative findings will corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative finding will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 5/5/19	r s of for ll be e gs	

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS	S FOR MEDICARE &	MEDICAID SERVICES	T		ONSTRUCTION	(X3) DAT	TE SURVEY
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		MPLETED
AND PLAN OF	CORRECTION		A. BOILD				
		495259	B. WING			0	3/21/2019
MANE OF DE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	COMPEN ON OOM LEIGH			296	66 SLATE CREEK ROAD		
HERITAGE	HALL GRUNDY			GF	RUNDY, VA 24614		
0/4) (D	SUMMARY S	TATEMENT OF DEFICIENCIES	GI D		PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S	RECTION SHOULD BE	(X5) COMPLETION
(X4) ID PREFIX	/FACH DEFICIEN(CY MUST BE PRECEDED BY FULL	PREF	1	CROSS-REFERENCED TO THE A	PPROPRIATE	DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)			DEFICIENCY)		
F 695	Continued From pag	ge 57	F	695			
	The facility policy titl	ed "Departmental		1			
	(Respiratory Therap	y)-Prevention of Infection"					
	read in part "Steps i	n the Procedure Infection					
	Control Consideration	ons Related to Oxygen		ĺ			
	Administration. 7.	Change the oxygen cannulae					
	and tubing every se	ven (7) days, or as needed.		1			
	8. Keep the oxyger	cannulae and tubing used					
	prn (as needed) in a	a plastic bag when not in use.					
	Steps in the Proced	lure Infection Control	ļ				
	Considerations Rela	ated to Medication					
	Nebulizers/Continue	ous Aerosol-7. Store the circuit					
	in plastic bag, mark	ed with date and resident's					
	name, between use	es.					E
	No further informati	ion was provided prior to the					
	exit conference on	3/21/19.	1				
	4. The facility staff	failed to ensure Resident #72's					
	bipap mask, headg	ear, and nebulizer mask were					
	stored in a plastic t	pag when not in use. The					
	facility staff also fai	led to ensure Resident #72					
	received the physic	cian ordered amount of oxygen.					
	The elipidal record	of Resident #72 was reviewed					
	2/10/10 through 3/	21/19. Resident #72 was					
	admitted to the fac	ility 3/8/16 and readmitted					
	0/24/18 with disan	oses that included but not					
	limited to above th	e knee amputation, acute					1
	diastolic heart failu	re, chronic obstructive					L.
	pulmonary disease	e, insomnia, psoriasis,					
	gastro-esophagea	l reflux disease,					
	hypothyroidism, V	itamin deficiency, anemia,					
	muscle weakness	, obesity, hypertension,					
	varicose veins of l	eft lower extremity, type 2					
	diabetes mellitus,	and mononeuropathy.					
	Docident #70's sig	gnificant change in minimum					
	dota cet (MDS) ce	ssessment with an assessment					
	reference date (Al	RD) of 2/25/19 assessed the					
	Telcrence date (A	Obsoleto Event ID:	CD5211		Facility ID: VA0102	If continuation	n sheet Page 58 of 8

NTERS FOR MEDICARE &	MEDICAID SERVICES					10. 0930-039 I
MENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1		STRUCTION	(X3) DATE SURVEY COMPLETED	
LAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDII	NG			
	495259	B. WING_				3/21/2019
ME OF PROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP COD	Œ	
				LATE CREEK ROAD		
RITAGE HALL GRUNDY			GRUN	IDY, VA 24614	ODDECTION	(X5)
(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 695 Continued From page resident with a BIMS status) as 15/15. So Procedures and Procedures an	G (brief interview for mental ection O Special Treatments, ograms was marked for resident. ent comprehensive care plan with onset date of 3/1/19 that it risk for c/o (complaints of) breath) r/t (related to) dx (chronic obstructive), has dx: allergies and dx: pnea. Approaches: Provide lered. eved Resident #72 during the 19 at 8:57 a.m. Resident #72 in his wheelchair with an tached to the wheelchair. The irrned to 3 liters. Resident #72	F	695			
was in the process appointment and the staff were in attend one of the member and the EMS staff. Also during the initial observed to have facemask on the remachine with face plastic bag. The rewith a towel. The surveyor information of the above a	of being transported to an the emergency medical services dance. The surveyor asked is to read the oxygen amount stated "3." tial tour, Resident #72 was bipap headgear and a hightstand as well as a nebulizer mask. None were stored in a nebulizer machine was covered immed licensed practical nurse and asked the nurse to come to tom. L.P.N. #2 was shown the					

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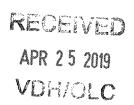
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
	495259	B. WING_		0	3/21/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL GRUNDY			STREET ADDRESS, CITY, STATE, Z 2966 SLATE CREEK ROAD GRUNDY, VA 24614	JP CODE	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
were reviewed. On (at bedtime) with se Remove bipap (at 7 per minute) via nas dx: SOB (shortnes (sulfate) 2.5mg/3ml 1 via neb (nebulize SOB." The surveyor obset 3/19/19 at 4:01 p.m his wheelchair with liters as ordered. The surveyor inform director of nursing, nurse of the above p.m. and again on requested the facility care. The facility policy ti (Respiratory Thera read in part "Steps Control Consideral Nebulizers/Continuin plastic bag, mark name, between us No further informate exit conference on 5. The facility staff the bipap settings failed to ensure Reference on the surveyor in the surveyor obsettings failed to ensure Reference on the surveyor obsettings and the surveyor obsettings failed to ensure Reference on the surveyor obsettings and the surveyor obsettings failed to ensure Reference on the surveyor obsettings and the surveyor obsettings failed to ensure Reference on the surveyor obsettings are surveyor obsettings and the surveyor obsettings are surveyor obsettings are surveyor obsettings are surveyor obsettings and the surveyor obsettings are surveyor o	cch 2019 physician's orders ders read "Apply BIPAP QHS ettings of 18/10 with rate of 20, 7:00 a.m.), O2 at 3 L/min (liters al cannula, prn (as needed) so foreath), and Albuterol sul (milliliter) soln (solution) Give r) q (every) 8 hrs (hours) dx: eved Resident #72 again on a. Resident #72 was sitting in oxygen at 2 liters/nc-not 3 end the administrator, the and the corporate registered concerns on 3/19/19 at 6:00 3/20/19 at 4:34 p.m. and ty policy on oxygen/nebulizer ettled "Departmental py)-Prevention of Infection" in the Procedure Infection ions Related to Medication ious Aerosol-7. Store the circuit ked with date and resident's es."	F	695		

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

Event ID: CD5211

Facility ID: VA0102

If continuation sheet Page 60 of 88



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL1 A. BUILDI		ONSTRUCTION	(X3) DATE S COMPL	
		495259	B. WING			03/2	1/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			296	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	stand during the residence of the clinical record of reviewed 3/19/19 thread the control of the clinical record of reviewed 3/19/19 thread the clinical record of reviewed 3/19/19 thread the clinical record of reviewed 3/19/19 thread the clinical record of reviewed and the clinical record of record of record of record of the clinical record of r	e observed lying on the night dent interview on 3/19/19. Resident #159 was ough 3/21/19. Resident /14/19 with diagnoses that ed to severe bilateral chronic dobesity, obstructive sleep and reflux uropathy, diabetes mellitus, erlipidemia, flux disease, and methicillin ocus aureus and MDRO organism) to bilateral lower at #159 was on contact with the first of the first	F	695			

DEIMIN	S EOD MEDICARE &	MEDICAID SERVICES					<u>J. 0938-039 I</u>
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CON	ISTRUCTION		E SURVEY PLETED
		495259	B. WING			0	3/21/2019
	ROVIDER OR SUPPLIER			2966	ET ADDRESS, CITY, STATE, ZIP CODE SLATE CREEK ROAD NDY, VA 24614		
(X4) ID PREFIX TAG	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	The surveyor review oxygen concentrator policy titled "Departrator Therapy)-Prevention "Steps in the Proced Considerations Relator. Change the oxygseven (7) days, or a oxygen cannulae an needed) in a plastic in the Procedure Interested to Medicati Aerosol-7. Store the with date and reside with date and reside exit conference on Based on observat document review a facility staff failed to was stored propert changed every 7 d survey sample (Reand #23). The findings included the series of the facility staff tubing for Resident #13 was series of the survey sample (Resident #13 was series).	red the facility policy for rs on 3/21/19. The facility mental (Respiratory of Infection" read in part dure Infection Control ated to Oxygen Administration. It gen cannulae and tubing every is needed. 8. Keep the of tubing used profession Control Considerations on Nebulizers/Continuous of circuit in plastic bag, marked ent's name, between uses." It ion was provided prior to the 3/21/19. It ion, staff interview, facility and clinical record review the of ensure respiratory equipment of y and the oxygen tubing anys for 5 of 26 residents in the esident #13, #73, #72, #159, and the oxygen tubing are facility in the sident #13 when changed. If alled to date the oxygen at #13 when changed.	F	695			
	3/12/19. On the a Set) with an ARD of 1/3/19, the resident BIMS (Brief Interval) 15 out of a possible was also coded a	nen readmitted to the facility on dmission MDS (Minimum Data (Assessment Reference Date) dent was coded as to having a riew for Mental Status) score of le score of 15. Resident #13 s requiring extensive assistance s for dressing, personal hygiene	The second secon				short Page 62

CENTERS	FOR MEDICARE &	MEDICAID SERVICES					0938-0391
	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE (COMPL	
		495259	B. WING			03/2	1/2019
	OVIDER OR SUPPLIER HALL GRUNDY			2966	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614		
(X4) ID PREFIX TAG	/EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 759	10:15 am, the surve wearing oxygen. Usurveyor could not tubing to indicate we on 3/20/19 at 10 at observed the reside was no date on the when it had been of the when it had been of the wear of the surveyor oxygen. The direct staff was to change week and when the tubing with a date on 3/21/19 at 8 and provided a copy of (Respiratory There of Respiratory There of Medication CFR(s): 483.45(f) Medication CFR(s): 483.45(f) Medication tubing with a date on 3/21/19 at 8 and provided a copy of (Respiratory There of Respiratory There of Respiratory There of Medication CFR(s): 483.45(f) Medication CFR(s): 483.45(f) Medication tubing with a date of the policy read in cannulae (sic) and needed"	ar of the facility on 3/19/19 at eyor noted Resident #13 was pon further investigation, the find a date on the oxygen then it had been changed. In, the surveyor again ent wearing oxygen but there oxygen tubing to indicate thanged. In of the above documented eyor requested a copy of the egards to the administration of tor of nursing stated that the enterest that the enterest that the enterest experimental experimen		695 F 759	F759 Corrective Action(s): Resident #29's attending phy notified that resident #29 did the correct dose of Sertraline observed medication pass. L involved in the medication p observation has received one inservice training on medica administration administration. A lecident & Accident form we for each medication arror.	I not receive c during an PN #2 cass c-on-one tion ats of A facility	
	polocia oi giodioi	Obsolute Event ID: C			for each medication error.	If continuation sh	eet Page 63 of

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		OATE SURVEY COMPLETED	
		495259	B. WING			03/2	1/2019	
NAME OF F	PROVIDER OR SUPPLIER			l	REET ADDRESS, CITY, STATE, ZIP CODE			
HEDITAG	E HALL GRUNDY			1	66 SLATE CREEK ROAD			
HENIAG	E HALL GROND!			G	RUNDY, VA 24614			
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 759	This REQUIREMEN by: Based on staff inter and during a medication, the fact medication error rate 2 errors in 25 opport rate of 8%. These mand the findings included 1. For Resident #29 and # The findings included 1. For Resident #29 administer the corresponding for the corresponding of the corresponding	view, clinical record review, stion pass and pour lity staff failed to ensure a e of less than 5%. There were tunities for a medication error redication errors effected 46. d: , the facility staff failed to ct dosage of the Resident mitted to the facility 04/11/18. , but were not limited to, sorder, dementia, atrial al vascular disease, and	F	759	Resident #46's attending physician we notified that resident #46 did not received their Zantac as ordered by the physiciduring an observed medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was complifor each medication error. Identification of Deficient Practices Corrective Actions(s): All residents may have potentially be affected. A 100% medication pass aud all licensed nurses within the facility be conducted to identify those nurses risk for Medication Administration ar technique errors. A facility Incident & Accident form will be completed for enegative finding as well as one-on-on inservice training and appropriate disciplinary action if warranted for nursing staff observed. Systemic Change(s): The facility Policy and Procedure for medication administration and has be reviewed and no changes are warranted this time. All Licensed nursing staff whe inserviced by the DON or ADON of the facility policy and procedure for medication administration. Inservices include administering medication per physician order and the 5 rights of medication administration.	ive an LPN eted & en it of will at dd/or each e		

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE C	ONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	1			'	OMM CEILED	
		495259	B. WING		1114		03/21/2019	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL GRUNDY				RUNDY, VA 24614			
(X4) ID PREFIX TAG	/FACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 759	label. After the medication the surveyor reconci medications. The cli for sertraline 25 mg daily. The Resident sertraline it had been mg. On 03/20/19 at 9:21 #2 checked the medication. LPN #2 from the medication dose) and sertraline #2 verbalized that sethought she had adhanded the surveyor. The administrator an notified of the issue sertraline on 03/20/19. No further informati provided to the surveyor administer the Resident #46 had been re-acceptage of the provided to the surveyor and the surveyor the clinical record #46 had been re-acceptage of the provided to the surveyor and the surveyor and the surveyor the clinical record #46 had been re-acceptage of the surveyor the clinical record #46 had been re-acceptage of the surveyor the clinical record #46 had been re-acceptage of the surveyor the clinical record #46 had been re-acceptage of the surveyor the clinical record #46 had been re-acceptage of the surveyor the survey	pass and pour observation led the Residents nical record included orders give one tab po (by mouth) was previously on 50 mg of n changed on 01/25/19 to 25 a.m., the surveyor and LPN dication cart for this pulled 2 medication cards a cart sertraline 25 mg (current to 50 mg (previous dose). LPN the could not be sure but ministered the 25 mg and for the wrong card. Ind nurse consultant were a regarding the Residents 19 at 9:49 a.m. Ion regarding this issue was vey team prior to the exit 5, the facility staff failed to idents zantac. review revealed that Resident dmitted to the facility 09/21/07. d, but were not limited to,	F	759	Monitoring: The Director of Nursing is resmaintaining compliance. The Manager and/or designee will threerandom weekly medication passobservations of licensed remonitor for compliance. Any findings will be addressed at discovery and appropriate disaction will be taken. All discretion din these audits will be refused the Quality Assurance Commercial review, analysis, and recommercial for change in facility policy, and/or practice. Completion Date: 5/5/19	DON, Unit conduct on curses to negatives the time of ciplinary epancies reported to ittee for cendations		

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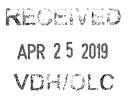
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE : COMPL	
		495259	B. WNG_			21/2019
	OVIDER OR SUPPLIER HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP COD 2966 SLATE CREEK ROAD GRUNDY, VA 24614	ĐĒ	
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 759	date) of 02/06/19 hindicate the Reside short term memory in cognitive skills for On 03/20/19 at 7:3 LPN (licensed pracadminister Resider These medications januvia, valsartan, carbamazepine, set When reviewing the was noted that the multivitamin, artific chloride, and zantathese medications. UPN and administered and administered and administered and administered and the set on 03/20/19 at 9:2 interviewed LPN # medications. LPN and administered and administered and administered and administrator notified of the issurgantac on 03/20/1 No further information provided to the su conference.	a ARD (assessment reference ad been coded 1/1/2 to nt had problems with long and and was moderately impaired or daily decision making. B a.m., the surveyor observed tical nurse) #1 prepare and at #46's morning medications. included atenolol, enalapril, hydrochlorothiazide, enna, loratadine, and lactulose. B Residents physician orders it Resident also had orders for ial tear eye drops, sodium ac. The surveyor did not see administered. S a.m., the surveyor 1 regarding the missed #1 stated she had went back everything but the zantac. LPN remember the zantac." After a (electronic health record) LPN at the zantac. and nurse consultant were are regarding the Residents 9 at 9:49 a.m.		F761 Corrective Action(s): LPN #2 has received on inservice training from to on the Medication Adm to include storing all me locked medication cart	the DON/designee inistration Policy edications in a when medication	
F 761	CFR(s): 483.45(g)			is not in line of sight or Licensed Nurse. A facil accident report was con incident.	in control of the lity incident &	

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

Event ID: CD5211

Facility ID: VA0102

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B, WING			03/2	/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE	E HALL GRUNDY				66 SLATE CREEK ROAD RUNDY, VA 24614		
					PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE
F 761	Drugs and biologic labeled in accordar professional principal professional principal professional principal propriate access instructions, and the applicable. §483.45(h) Storag §483.45(h)(1) In a Federal laws, the biologicals in locket temperature contripersonnel to have §483.45(h)(2) The locked, permanent storage of controll the Comprehensival Control Act of 197 abuse, except who package drug distipation quantity stored is be readily detected this REQUIREMED by: Based on observice document review,	cals used in the facility must be note with currently accepted ples, and include the sory and cautionary ne expiration date when the expiration date with the expiration and the expiration of the expiration and the expiration of the expir	F	761	The 3cc normal saline syringe found in resident #46's room was disposed of. LPN #2 responsible for overseeing the care of resident 46 has received disciplinary action for leaving medicat at the resident's bedside unattended and has received one-on-one inservice traifform the DON/designee on proper medication administration and storage medications in a locked medication can when not in the line of site or in contract the licensed nurse. A facility Incident accident form was completed for this incident. Identification of Deficient Practices Corrective Action(s): All unit Medication Carts and resider rooms may have been potentially affer The DON and/or designee will conduct 100% review of all licensed nurses of medication passes to identify any medication carts that are left unlocked unattended during medication passes. A 100% review of all resident rooms be completed to identify any resident rooms with medications or biological in the resident rooms unattended. An negative findings will be corrected a of discovery. A facility Incident and Accident form will be completed fo incident identified.	ion ad ning of art of of & at ected. act a uring ad or a s will t als left ny/all at time	
	units, unit C. The findings inclu 1. The facility state omeprazole, LPN	ded: If failed to secure the medication I (licensed practical nurse) #2			Systemic Change(s): Facility policy and procedure for medication and biological storage here been reviewed and no changes are warranted at this time. All licensed will be inserviced by the DON and	nurses /or	
	the top of the med				regional nurse consultant on the fact policy and procedure for storing medications and biological to inclu	cinty	
I	On 03/20/19 at 7:	53 a.m., during a medication			1		l

DELIGITA	AIDINE OF THE COLOR	MEDICAID SERVICES				OMB NO). <u>0938-0391</u>
STATEMENT O	S FOR MEDICARE & DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY PLETED
		495259	B. WING			03	/21/2019
	ROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 166 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	/FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE	(X5) COMPLETION DATE
F 761	pass and pour obseresidents stock meadministration. After looking through stated she would had from the medication medication room an omeprazole. Upon recart LPN #2 stated the correct medication check a drug bod omeprazole on top went down the hall medication on top at then returned to he medication for adm. The surveyor obsering the hall way during out of the vicinity of their view, LPN in nervous. The administrator in of their view, LPN in nervous. The administrator in of their view, LPN in nervous. The administrator in the hall medication for the issurbeing left on top of 03/20/19 at 9:49 at the information of their view, LPN in nervous. The administrator in the information of their view in the information of their view in the information of their view in the information of the information o	rvation LPN #2 did not have a dication esomeprazole for the medication cart LPN #2 ave to obtain the medication room. LPN #2 went to the did obtained a bottle of returning to the medication she did not know if this was ion and stated she was going ok. LPN #2 left the bottle of of the medication cart and leaving her cart with the and out of her view. LPN #2 or cart with another bottle of inistration. Inved 3 different staff members of the period that LPN #2 was fine the medication cart. 1 a.m., LPN #2 was asked medication unattended and out #2 stated she had gotten and nurse consultant were the regarding the medication if the medication cart on	F	761	leaving medications on the medicate carts or in resident rooms unattended. Pharmacy consultant will check ear medication carts and medication roimproper storage of medications medications medications medications. Monitoring: The DON is responsible for maintended compliance. The DON or designed perform 3 random weekly audits of medication carts medication room resident rooms to monitor for contact All discrepancies found in these awill be corrected at the time of distant appropriate disciplinary action as warranted. Results of these audications for review, analysis, a recommendations for change in figure policy, procedure, and/or practices. Completion Date: 5/5/19	aining e will of the is and ipliance. udits scovery n taken lits will nce ind acility	

	OF OR WILDION IN LE C	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII	TIPLE	CONSTRUCTION	(X3) DATE	SURVEY
	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	1''			COMPL	
- <u>-</u>		495259	B. WNG			03/2	21/2019
NAME OF P	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGI	E HALL GRUNDY			l	966 SLATE CREEK ROAD FRUNDY, VA 24614		
			1		PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	8E	COMPLETION DATE
F 761	9/21/07 with diagnos non-displaced fractu fibula, non-traumatic constipation, gastros hypertension, Vitami benign prostatic hyp type 2, chronic hepa anemia. Resident #46's signi data set (MDS) assereference date (ARE resident with a BIMS status) as 15/15.	by 6/27/17 and readmitted the state included the subdural malleolus right is subdural hemorrhage, esophageal reflux disease, in deficiency, convulsions, erplasia, diabetes mellitus titis, dry eye syndrome, and ficant change in minimum essment with an assessment of 6 (brief interview for mental	F	761			
	On 3/19/19 at 5:00 p.m., the surveyor entered the room of Resident #46 to interview the resident. Upon entrance to the room, the surveyor observed a syringe labeled Normal Saline 3cc (cubic centimeters) IV (intravenous). The syringe was in a plastic protective sleeve. The surveyor did not observe a needle on the syringe. The surveyor informed licensed practical nurse #2 of the above observation and gave the syringe to her. L.P.N. #2 stated Resident #46's						
	roommate was trans morning and the syn resident.	sferred to the hospital this ringe was on hand for that ot have March 2019 physician					
	director of nursing a	ned the administrator, the and the corporate registered 5:40 p.m. and requested the dication storage.					

PRINTED: 04/11/2019 FORM APPROVED OMB NO. 0938-0391

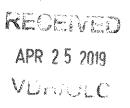
STATEMENT O	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '		NSTRUCTION	(X3) DATE : COMPL	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG			
		495259	B. WING			03/2	21/2019
NAME OF PE	ROVIDER OR SUPPLIER			i	ET ADDRESS, CITY, STATE, ZIP CODE SLATE CREEK ROAD		
HERITAGE	E HALL GRUNDY				INDY, VA 24614		
(X4) ID PREFIX	/EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	OULD BE	(X5) COMPLETION DATE
TAG	REGULATORTOR	LOO IDENTIFICATION OF THE PROPERTY.			DEFICIENCY)		
F 761	The facility policy title read in part "8. Drug manner in cabinets, dispensing systems, shall be assigned to or other holding area mixing medications.	ed "Storage of Medications" s shall be stored in an orderly drawers, carts, or automatic Each resident's medications an individual cubicle, drawer, a to prevent the possibility of of several residents."	F	761	F842		
F 842 SS=D	exit conference on 3 Resident Records - CFR(s): 483.20(f)(5 §483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a grees not to use of except to the extent to do so. §483.70(i) Medical §483.70(i)(1) In accurate and must maintain meditat are— (i) Complete; (ii) Accurately doct (iii) Readily access (iv) Systematically §483.70(i)(2) The all information con regardless of the forecords, except with the contraction of the cords, except with the cords.	Identifiable Information (), 483.70(i)(1)-(5) ent-identifiable information. I release information that is to the public. I release information that is to an agent only in contract under which the agent or disclose the information to the facility itself is permitted records. Cordance with accepted ands and practices, the facility lical records on each resident amented; sible; and organized facility must keep confidential tained in the resident's records, orm or storage method of the	F	842	Corrective Action(s): Resident #46's medical record reviewed and the misfiled Uring results for resident #160 have be removed from resident #46's medical record. A facility incident accident form has been comples incident. Resident #94's Durable Do No Resuscitate (DNR) has been of has been filed in resident #94's record. A facility incident and form has been completed for the Identification of Deficient Pr Corrective Action(s): All other residents may have proposed been affected. A 100% audit or resident medical records will be conducted by the DON, ADOI Medical Records clerk to iden residents at risk for an inaccur record filing and missing DNE documentation. All negative from the incident. A fac & Accident form will be compeach negative finding.	e culture seen sedical 60's lent and sted for this st otained and s medical accident nis incident. cactices & sotentially of all se Nand/or stify rate medical cactings will st time of hysician ility Incident	

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

Event ID; CD5211

Facility ID: VA0102

If continuation sheet Page 70 of 88



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495259	B. WING			03/	21/2019
•	OF PROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 166 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) PRE TA	EX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	- 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F	(ii) Required by La (iii) For treatment, operations, as per with 45 CFR 164.5 (iv) For public heal neglect, or domest activities, judicial a law enforcement p purposes, researc medical examiners a serious threat to by and in complian §483.70(i)(3) The record information unauthorized use. §483.70(i)(4) Med for- (i) The period of ti (ii) Five years fron there is no require (iii) For a minor, 3 legal age under S §483.70(i)(5) The (i) Sufficient infor (ii) A record of the (iii) The comprehe provided; (iv) The results of and resident revie determinations co (v) Physician's, no professional's pro (vi) Laboratory, ra	pre permitted by applicable law; w; payment, or health care mitted by and in compliance 06; th activities, reporting of abuse, ic violence, health oversight and administrative proceedings, urposes, organ donation in purposes, or to coroners, is, funeral directors, and to avert health or safety as permitted nee with 45 CFR 164.512. Ifacility must safeguard medical against loss, destruction, or it the date of discharge when in State law; or a the date of discharge when sement in State law; or years after a resident reaches tate law. Immedical record must containation to identify the resident; resident's assessments; ensive plan of care and services any preadmission screening ew evaluations and inducted by the State; urse's, and other licensed	F	842	Systemic Change(s): The facility policy and procedure habeen reviewed and no changes are warranted at this time. All licensed nursing staff and Medical Records of will be inserviced by the DON or renurse consultant on the clinical documentation standards per facility policy and procedure. This training include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical informat the appropriate medical record and maintaining DNR forms and advandirectives in the resident medical record in the resident medical record in the designee will perform weekly char coinciding with the care plan calen monitor for compliance. Any/all not findings will be clarified and corretime of discovery and disciplinary will be taken as needed. The result this audit will be provided to the CAssurance Committee for analysis recommendations for change in fa policy, procedure, and/or practice. Completion Date: 5/5/19	lerk gional will g al ion in ce cord. ining l/or t audits dar to egative cted at action is of quality and cility	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		MPLETED
		495259	B. WING_			3/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, 2966 SLATE CREEK ROAD GRUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVI CROSS-REFERENCEI	NY OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 842	This REQUIREMEN' by: Based on staff intented review, and clinical realized to ensure a corecord for 2 of 26 rest Resident #94). The findings included 1. The facility staff in Resident #160's laber clinical record. The had physician orders #160 and had been nurse #1 (L.P.N. #1) The clinical record of 3/19/19 through 3/2 admitted to the facility 9/21/07 with diagnor non-displaced fracture fibula, non-traumatic constipation, gastron hypertension, Vitambenign prostatic hyptype 2, chronic hepatanemia. Resident #46's sign data set (MDS) ass reference date (ARI resident with a BIM status) as 15/15. The surveyor review section on 3/21/19. surveyor found the	view, facility document record review, the facility staff record review, the facility staff replete and accurate clinical sidents (Resident #46 and d: ncorrectly filed the results of pratory test on Resident #46's 1/14/19 urine culture results of pratory test on Resident record by licensed practical process of the prac	F	842		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B. WING_			03/2	21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			29	REET ADDRESS, CITY, STATE, ZIP CODE 1966 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3€	(X5) COMPLETION DATE
F 842	Continued From page	e 72	F	842		A	
	antibiotic-Cipro 500 r x 5 days-dated 1/14/	ad specific orders for an ng (milligrams) q (every) 12 19 written by the family nurse d by licensed practical nurse					
	Resident #46 did not culture and sensitivity	have an order for a urine y in January 2019.					
	to the facility 12/18/1 diagnoses that include infarction, hemiplegia affecting left non-dor cardiomegaly, hyper hyperlipidemia, anxiety uropathy, acute upper	esident #160 was admitted 8 and readmitted 1/7/19 with ded but not limited to cerebral a following cerebral infarction minant side, ST elevation,					
	with an assessment 2/5/19 assessed the memory problems, keeping and moderately impa	day minimum data set (MDS) reference date (ARD) of resident with short term ong term memory problems, aired cognitive skills for cisions poor; needs cues and					
	1	orders dated 1/10/19 for a UA culture/sensitivity dx ia.	With the second				
	(DON) of the above a.m. The surveyor a who was responsible the medical record.	ed the director of nursing concern on 3/21/19 at 10:19 asked the director of nursing e for filing laboratory results in The DON stated (other #1) at the laboratory results. The					

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO	0938-0391
STATEMENT C	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495259	B, WING			03/2	21/2019
	ROVIDER OR SUPPLIER			290	REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	(FACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 842	surveyor requested. The facility policy titl Documentation" rea the medical record vand accurate." No further informatic exit conference on 3. 2. The facility staff #94's DNR (do not clinical record. The clinical record of 3/19/19 through 3/2 admitted to the facility 1/14/18 with diagnoral limited to acute on clinical cerebral infarction aside, type 2 diabeted Resident #94's qual (MDS) assessment reference date (AR resident with a BIM status) as 15/15. Resident #94's Maread "Do Not Result/15/18." The surveyor reviews unable to local informed the assis	the facility policy on charting. ed "Charting and d in part "3. Documentation in vill be objective, complete, on was provided prior to the	F	842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495259	B. WING_		03/21/2019		
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CO 2966 SLATE CREEK ROAD GRUNDY, VA 24614			
(X4) ID PREFIX TAG	(FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C ((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE		
F 842	The assistant direct informed the survey locate the DDNR (of the clinical record. was called and the DDNR to the facility. The facility policy to Documentation" retthe medical record and accurate." No further informate exit conference on Infection Prevention CFR(s): 483.80(a) (a) §483.80 Infection prevention designed to provide comfortable environment and diseases and infection program. The facility must earn development and diseases and infection program. The facility must earn development and control program a minimum, the form §483.80(a)(1) A streporting, investig and communicable staff, volunteers, providing services arrangement based arrangement	tor of nursing (ADON) yor that she was not able to durable do not resuscitate) in The ADON stated the hospital hospital faxed a copy of the y. Itled "Charting and ad in part "3. Documentation in will be objective, complete, Ition was provided prior to the 3/21/19. In & Control (1)(2)(4)(e)(f) Control stablish and maintain an In and control program Ite a safe, sanitary and Inment and to help prevent the transmission of communicable ctions. In prevention and control Instablish an infection prevention am (IPCP) that must include, at		F880 Corrective Action(s): The soiled linen in the flo and the floor was cleaned policy/procedure. C.N.A. dirty linen on the floor of room after morning care he disciplinary action and on inservice training by the inpreventionist on the properties of soiled linen. A incident & accident form for this incident. The attending physician for was notified that the faciliensure the correct Isolation were implemented when resident #259 and the faciliensure the correct Isolation were implemented when resident #259 and the faciliensure the correct Isolation were implemented when resident #259 and the faciliensure the correct Isolation were implemented when resident #259 and the faciliensure the correct Isolation were implemented when resident #259 and the faciliensure the correct Isolation were implemented when resident #259 and the faciliensure the correct Isolation were implemented when resident #259 and the faciliensure the correct Isolation was compared to the facility in the facility in the facility in the facility is a contraction of the facility in the	per facility . #1 who placed Resident #63's nas received ne-on-one infection er storage and A facility was completed for resident #259 ity failed to on precautions caring for ility did not eptacle for ior to leaving the Incident &		

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED		
		495259	B. WING			03/21/2019		
	ROVIDER OR SUPPLIER E HALL GRUNDY			29	REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614			
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 880	accepted national star \$483.80(a)(2) Writter procedures for the procedure of survei possible communicatinfections before they persons in the facility (ii) When and to who communicable disease reported; (iii) Standard and trait to be followed to prev (iv) When and how is resident; including but (A) The type and during depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstances contact with resident contact will transmit if (vi) The hand hygiene by staff involved in displaying the staff involved in displayi	standards, policies, and ogram, which must include, allance designed to identify pole diseases or a can spread to other impossible incidents of the or infections should be a manission-based precautions are the procedure of the isolation, infectious agent or organism at the isolation should be the able for the resident under the assumed with a communicable kin lesions from direct the disease; and a procedures to be followed irect resident contact.	Ę.	880	Resident #310's order for isolation we clarified with the physician on 3/19/11 and the physician discontinued the isolation. The LPTA who entered the resident's room without donning PPE has received isciplinary action and one-on-one inservice training by the infection preventionist on donning/doffing PPI CNA #1 who exited resident #159's without washing her hands has received isciplinary action and one-on-one inservice training from the infection preventionist on donning/doffing PPI handwashing. Identification of Deficient Practices and Corrective Action(s): All residents may have the potential affected by improper infection contropractices related to isolation and PPE The Infection Preventionist has clarified isolation orders on all residents with current isolation orders with their respective attending physicians. All staff have been inserviced on the isolation precautions in place for all residents currently having orders for isolation. Additionally, all staff have received inservice training on donning/doffing PPE; required equipment; and handwashing.	syed syed coom ded and so be ol cool		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495259	B. WNG_	B. WNG		03/21/2019	
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ζ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(f) Annual reverse The facility will condul PCP and update the This REQUIREMENT by: Based on observation staff interview and facility staff failed to for control procedures for #259, #310, #81 and The findings included. 1. For Resident #63, ensure that dirty liner. The clinical record re #63 had been admitted Diagnoses included, weakness, heart failed dementia, and hyper. Section C (cognitive annual MDS (minimulan ARD (assessmen had been coded 1/1/1) had problems with loand was moderately for daily decision material was moderately for daily decision material materials. On 03/19/19 at 8:59 facility, the surveyor crumpled up linen in The Resident was up Residents bed was colinen. During this obsumursing assistant) #1	view. Ict an annual review of its its program, as necessary. Is not met as evidenced In, clinical record review, cility document review the ollow established infection or 5 of 26 Residents,#63, #159. It: Ithe facility staff failed to make kept off the floor. It wiew revealed that Resident ed to the facility 09/20/17. but were not limited to, are, Alzheimer's disease, tension. In patterns) of the Residents are data set) assessment with the reference date) of 02/18/19 2 to indicate the Resident ng and short term memory impaired in cognitive skills	F8	880	The infection preventionist/designed review isolation orders for residents a each morning standup meeting. When residents reside in the facility a have isolation orders, the infection preventionist will complete 3 weekly observations of staff and/or visitors to ensure proper use. Any negative findings will be address immediately, and disciplinary action taken as needed. A facility Incident a Accident form will be completed for negative finding. Systemic Change(s): The facility Infection Control policy medication administration policy and procedure have been reviewed and nuchanges are warranted at this time. Infection preventionist has inserviced staff on transmission based precauted donning/doffing PPE; required equipment; and handwashing. The infection preventionist has also reinserviced nursing staff on visitor education of donning/doffing of PPI.	and and i o rhe d all ons;	

FORM APPROVED OMB NO. 0938-0391

PRINTED: 04/11/2019

OCHTCD!	CENTERS FOR MEDICARE & MEDICAID SERVICES						<u>0. 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED	
		495259	B, WING			0:	3/21/2019
	ROVIDER OR SUPPLIER			29	REET ADDRESS, CITY, STATE, ZIP CODE 166 SLATE CREEK ROAD RUNDY, VA 24614		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	linen was supposed is not and placed the on the hall. On 03/20/19 at 11:2 with the infection coverbalized to the sulinen in the floor dur. The administrative of regarding the Resid with the survey tear and again on 03/20. No further informating provided to the survey tear and again on 03/20. The further informating provided to the survey the Resider and failed to provide and failed to provide pPE (personal profit provided to, weakness that the provided to, weakness that the provided to, weakness that the provided to the survey of the clinical record resident had been 03/14/19. Diagnoss limited to, weakness that the provided to the survey of the clinical record resident had been 03/14/19. Diagnoss limited to, weakness that the provided to the survey of the clinical record resident was all place.	to be in floor she stated no it is linen in a closed barrel out as a.m., during an interview introl nurse this nurse received that they discussed ing CNA meetings. Staff were notified of the issue lents linen during a meeting in on 03/19/19 at 5:40 p.m. In on regarding this issue was vey team prior to the exit in the correct isolation less a container for disposal of	F	880	Monitoring: The infection preventionist is responsive for maintaining compliance. The infection preventionist will review isolation orders with facility leader during the weekly risk mgmt and we complete 3 weekly observations of and/or visitors to ensure proper use. Any negative findings will be corrected time of discovery and disciplinaction taken as needed. The infection preventionist will compliance of the indings will be addressed time of discovery and disciplinary. Aggregate findings will be addressed time of discovery and disciplinary. Aggregate findings of the reports submitted to the Quality Assurance. Committee quarterly for review, a and recommendations for change facility policy and procedure. Compliance Date: 5/5/19	ship vill staff ceted at ary mplete /or ly d at action. will be e nalysis,	
	approximately 8:4 identified this Res	of the facility on 05/19/19 at 5 a.m., the facility staff ident as being in contact proaching the Resident room, when a plastic container that					sehect Page 78

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	IPLE CON		(X3) DATE SURVEY COMPLETED		
		495259	B. WING			03/21/2019		
	ROVIDER OR SUPPLIER		•	2966 S	T ADDRESS, CITY, STATE, ZIP CODE BLATE CREEK ROAD IDY, VA 24614			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	sign outside the R the nurse. Prior to surveyor dressed facility. Upon removing the room, the surveyor infection control of The surveyor look asked the staff in staff placed a clos to discard the use On 03/19/19 at 9:3 director of nursing being in the Resid should have been During an intervier nurse on 03/19/19 infection control n on contact isolation doctor, and they w isolation. The infe Resident should h to place the dirty f was also asked to Resident should h On 03/20/19 at 11 nurse verbalized i messed up and th droplet isolation. I contact at the hos	oves, gown, and mask) and a esidents door that stated to see entering the room, the out in the PPE provided by the experience of the provided by the provided in the hall way and the hall about a container. The end barrel in the Residents room of the provided the provided by t	F	880				
		was placed on contact isolation had been discontinued on						

CENTERS FOR MEDICARE & MEDICAID SERVICES					OWB NO. 0938-039			
CENTERS FOR MED ATEMENT OF DEFICIENCIE ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			urvey eted	
		495259	B. WING			03/2	1/2019	
NAME OF PROVIDER OR SU				296	REET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD RUNDY, VA 24614)DE		
(X4) ID (FAC	SUMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ıx	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE [(X5) COMPLETION DATE	
The Resid the proble enterobace The facility Transmiss following, implement suspected transmitted by the industry of the indu	r information to the surface appropriate to the surface appropriate to the surface.	cent was in a private room. prehensive care plan included intact isolation related to imm. led "Isolation-Categories of differentiations" included the the precautions may be individual documented or ected with microorganisms letsthat can be generated ughing, sneezing, talking" staff were notified of the issue dents infection control status in p.m. and again on 03/20/19 ion regarding this issue was every team prior to the exit 10, the facility staff failed to interest infection control guidelines de a container for disposal of tective equipment). review revealed that the in admitted to the facility on es included, but were not ess, Parkinson's disease, a, and hypertension. Inpleted MDS (minimum data on this Resident. The Resident	F	880				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495259	B. WNG_		03/21/2019		
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CO 2966 SLATE CREEK ROAD GRUNDY, VA 24614	DE		
(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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 880	an isolation sign on the door this sign directed entering the room to a surveyor dressed out cart outside the Residente PPE, the surveyor infection control co	the outside of the Resident's digital any person that would be see the nursing staff. The in the PPE provided in the dents room. Upon removing r was unable to locate any ainer to place the used PPE. Out into the hallway and grassistant) #1 approached stated the Resident was not the signage was from the at was in this room. CNA #1 lation sign, repositioned the etwo rooms, and placed it ter the signage and PPE removed, a second surveyor	F	380			

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO	<u>, 0936-039 i</u>	
STATEMENT O	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495259	B. WNG			03/	21/2019
	ROVIDER OR SUPPLIER			296	REET ADDRESS, CITY, STATE, ZIP CODE 56 SLATE CREEK ROAD RUNDY, VA 24614		
HERITAGE	INCL GRORD					10M	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETION DATE
F 880	acknowledged she stated they had be when the Resident stated no one told isolation. I was in formal that the states are garding the states during a me 03/19/19 at 5:40 p. The Residents isologically that the states during a me 03/19/19. No further informal provided to the suconference. 4. For Resident # maintain an effect Resident #81 was 01/29/19. Diagnot cancer, coronary gastroesophages hyperplasia, h	had removed the sign and en off the weekend and that is that been admitted. CNA #1 me yesterday she was on the room yesterday. It staff were notified of the he Residents infection control peting with the survey team on the infection was discontinued on the facility staff failed to the facility staff failed to the infection control program. It he facility staff failed to the facility on ses included but not limited to artery disease, hypertension, all reflux disease, benign prostatic perlipidemia, hypothyroidism, nic obstructive pulmonary audomonas bronchitis. MDS (minimum data set) with ment reference date) of 02/05/19 ent as 5 out of 15 in section C, s. This is an admission MDS. CCP (comprehensive care plan) and contained a care plan for "At the of SOB (shortness of breath) resp. (respiratory) infections	F	880			
	Approaches for	liagnosis) bronchitis". this care plan included "Requires				If continuetion	sheet Page 82 of
		Sugart ID:	PD5211	1	Facility ID: VA0102	it continuation	SHEEL LAGE OF OL

	ENTO MEDICADE	MEDICAID SERVICES					U. 0936-0381
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII		STRUCTION		(X3) DATE SURVEY COMPLETED	
		495259	B. WING				3/21/2019
NAME OF PROVIDER OR SUPPLIER			2966 5	ET ADDRESS, CITY, STATE, ZIP COD SLATE CREEK ROAD	E		
HERITAGE	HALL GRUNDY			GRU	NDY, VA 24614	COLONI	(X5)
(X4) ID PREFIX TAG	/CACU DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	COMPLETION DATE
F 880	Continued From pa droplet isolation r/t sputum".	age 82 (related to) pseudomonas of	F	880			
:	observed LPTA (lice assistant) assistant the lunch tray for the	proximately 1230, surveyor censed physical therapy g with lunch trays. LPTA took the Resident's roommate, and without donning any PPE we equipment).		A DOWN THE REAL PROPERTY OF THE PERSON OF TH			
	on 03/20/19 at ap	oith the infection control nurse proximately 1325. Surveyor ontrol nurse if the LPTA should room without donning PPE, and rol nurse stated that he should		And the state of t			
	facility policy entity Transmission-Batter part "Droplet Prediction of the concern of notices and the concern of the concern o	uested and was provided with a titled "Isolation-Categories of sed Precautions", which read in cautions 3. Masks will be worn e room". ot following infection control was be administrative team during a 0/19 at approximately 1555.		A STREET, ST. SACROTTON BASES ST. SACROTTON BASES			
	5. The facility st the use of PPE (and the staff faile removing gloves	nation was provided prior to exit. aff failed to educate visitors on personal protective equipment) ed to perform hand hygiene after after assisting with wound care 19. Resident #159 was on		de de serve tables de la company de la compa			
	reviewed 3/19/1 #159 was admit	ord of Resident #159 was 9 through 3/21/19. Resident ted 3/14/19 with diagnoses that I limited to severe bilateral chronic torbid obesity, obstructive sleep			cility ID: VA0102	If continuation	on sheet Page 83

CENTERS FOR MEDICARE & MEDICARD SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDI	A. BUILDING			
		495259	B. WING			0:	3/21/2019
	ROVIDER OR SUPPLIER			2966 8	ET ADDRESS, CITY, STATE, ZIP CODE SLATE CREEK ROAD NDY, VA 24614		
		TATEMENT OF DEFICIENCIES	a l		PROVIDER'S PLAN OF COR	RECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	(EACH DEFICIEN(CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	PPROPRIATE	DATE
F 880			F	880			
	resistant staphyloco	diabetes mellitus,					
	Resident #159's ad (MDS) assessment	mission minimum data set had not yet been completed.	Livery of the Li				
	at 2:11 p.m. Reside door directing staff/ entering the room. room was a 3-draw gowns, and masks visitor sitting in the	rved Resident #159 on 3/19/19 ent #159 had a sign on the fvisitors to see nurse before Also at the entrance to the er cart containing gloves, The surveyor observed a chair at the end of Resident urveyor did not observe any					
	3/19/19 at 4:53 p.n	rved Resident #159 again on n. The 3-drawer cart did not The visitor was observed again e-no gloves or gowns.					
	director of nursing	med the administrator, the , and the corporate registered e concern on 3/19/19 at 5:55 d the infection control policy on is.		The second secon			
	on 3/20/19. The V	viewed Resident #159's visitor visitor was asked if any staff had nage on the door. The visitor					
	The surveyor obs	erved wound care on 3/20/19 at					a shoot Page 84

CENTERS FOR MEDICARE & MEDICAID SERVICES

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION	COMPLI		
		495259	B. WNG			03/2	1/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL GRUNDY				29	REET ADDRESS, CITY, STATE, ZIP CODE 66 SLATE CREEK ROAD RUNDY, VA 24614	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 880	Certified nursing ass gowned prior to ente completion of the wo soiled bandages in the and gowns and handremoved gloves and interviewed registered nurse of the above op.m. and interviewed registered nurse on infection control nurse. She stated hands or use purell. The surveyor review "Isolation-Categorie Precautions" on 3/2 "5. When a resident transmission-based notification is placed and on the front of the and visitors are away precaution. Contact Precautions 4. Staff and visitors non-sterile) when endeving the room are leaving the room are leaving the room and the government of the room are leaving the room are leavi	sed practical nurse #4. istant #1 had gloved and ring the room. Upon bund care, L.P.N. #4 placed he barrel, removed gloves dis were washed. CNA #1 gown and left the room. No ved or hand hygiene done. with L.P.N. #4 about the L.P.N. #4 stated, "She didn't ed the administrator, the and the corporate registered concern on 3/20/19 at 3:54 did the infection control 3/21/19 at 1:07 p.m. The se stated she was informed of ing her hands after removing she expected staff to wash ved the facility policy titled, s of Transmission-Based 1/19. The policy read in part is placed on precautions, appropriate d on the room entrance door he chart so that personnel are of the need for and type of s will wear gloves (clean, intering the room. will wear a disposable gown boom and remove before and avoid touching potentially commental surfaces with	F	880				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495259	B. WING		03/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614	
(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 CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 880	0 Continued From page 85		F 8	80	
F 921 SS=D	"Handwashing/Hand policy read in part: "7. Use an alcohol-bate least 62% alcohol; or for the following situat. It before donning stem. after removing glon. Before and after esettings. 8. Hand hygiene is the and disposing of personand stem. It and disposing of personand stem. It and disposing of personand stem. It is a long with routing as the best practice of healthcare-associated. No further information exit conference on 3. Safe/Functional/San CFR(s): 483.90(i) §483.90(i) Other Entropy and comformation residents, staff and the This REQUIREMEN by: Based on observations and hazard free the deck outside the The deck outside the The deck outside the The deck outside the the staff and the deck outside the The deck outside the the staff and the deck outside the The deck outside the the staff and the deck outside the The deck outside the the staff and the deck outside the the the staff and the deck outside the the the the the the the the the th	rile gloves oves. Intering isolation precaution one final step after removing sonal protective equipment. Integration of glove the hand hygiene is recognized for preventing and infections." In was provided prior to the I/21/19. Itary/Comfortable Environ I/21/19. I/21	F	F921 Corrective Action(s): The deck at the back of the facility identified as having rotten and warp deck boards has been completely ta down and removed from the facility. Identification of Deficient Practice and Corrective Action(s): All other residential, and common have the potential to be affected. To Maintenance Director will perform documented walkthrough inspection the facility to identify any areas of concern related to patient and staff or equipment repair needs. Any/All negative findings will be documented with the administrator to prioritize corrections that will need made.	ken /- ee(s) areas he a n of safety l ted and

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495259	B. WING_				03/21/2019
	ROVIDER OR SUPPLIER E HALL GRUNDY			296	EET ADDRESS, CITY, STATE, ZIP CODE 6 SLATE CREEK ROAD UNDY, VA 24614		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 921	On 3/19/19 at 3:00 p Resident #108, outsi Resident expressed able to use the outsi rotten. The surveyor immed area. The facility had the entryway to this was able to push the and gain access to ti The surveyor checke boards that were rot warped, and boards The surveyor asked maintenance directo accompany them to observation two dec that were rotten, spo boards were identified uneven. The facility administ director stated they the entryway. The n would stay in the are ambulatory Residen vicinity and another area during this obs dietician was able to outside from where area. There was no the initial observation	.m., during an interview with de the dining area, this a concern over not being de deck, as the deck was deck, as the deck was deck. However, the surveyor e park bench out of the way he deck. The deck and identified two ten, boards that were that were uneven. The facility administrator, or, and nurse consultant to the outside deck. During this king boards were identified tongy, and moveable. Other ed that were warped and that were warped and the world place a barrier across consultant stated she as until it was addressed. Two ofts were observed in the Resident came out into the ervation period. The facility of visualize the Residents she was sitting in the dining staff present outside during	F	921	Systemic Change(s): The facility's policy & procedure providing a safe, sanitary, and comfortable environment has bee reviewed. No changes are warrar this time. The Maintenance Direct provide inservices to all staff on the policy and procedure for proper notification to use when repairs a needed throughout the facility. The include reporting broken/unusable furniture, wheelchairs and other a care equipment. These maintenar request logs will be reviewed by administrator weekly for complete repairs. Monitoring: The Maintenance Director is rest for maintaining compliance. The Program includes facility audit to monitoring compliance. The Maintenance Director will compaudit weekly to monitor for com The results of these audits will be reported to the Quality Assurance Committee for review, analysis, recommendations for change in policy, procedure, and/or practice Completion Date: 5/5/19	n ated at tor will he re his will e resident ace the tion of lete the pliance. e e & facility	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE C	(X3) DATE SURVEY COMPLETED			
		495259	B. WING		03/21/2019		
	ROVIDER OR SUPPLIER E HALL GRUNDY		STREET ADDRESS, CITY, STATE, ZIP CODE 2966 SLATE CREEK ROAD GRUNDY, VA 24614				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 921	point and 2 foot at the had placed the park entranceway to the person as being the The facility administ director stated that entryway by nailing The surveyor check boards to be secure administrator stated the boards or may judministrator and madeck was inspected couple of boards had the surveyor intervous foot of the surveyor	off the ground at the lowest the highest. When asked who bench across the deck the facility identified this activity director. The facility had blocked off the boards across the entrance. The facility would either replace all facility would be facility assistant on the facility of the activity assistant on the facility was out of town and that the facility was out of town and that the facility was out of town and that the facility was caution tape and the facility was unsure as to who had she was unsure as to who had she was unsure as to who had she had across the entrance. The facility without staff. They	F 921	RECEIVEL APR 2 5 2019 VDH/OLC			