PRINTED: 03/19/2019 **FORM APPROVED** State of Virginia STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: B. WING 03/06/2019 VA0108 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST HERITAGE HALL BLACKSTONE **BLACKSTONE, VA 23824** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 F 000 Initial Comments 12 VAC 5-371-250 (F) & (G) Cross References to F656 An unannounced biennial State Licensure Inspection was conducted 3/4/19 through 3/6/19. Cross Reference POC for F656 Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure 12 VAC 5-371-200 B - Cross Reference to of Nursing Facilities. Complaints were F658 investigated during the survey process. The Life Cross Reference POC for F658 Safety Code survey/report will follow. 12 VAC 5-371-220 C1 - Cross Reference to The census in this 180 certified bed facility was F686 148 at the time of the survey. The survey sample consisted of 45 current record reviews and six Cross Reference POC for F686 closed record reviews. 12 VAC 5-371-220 B - Cross Reference to F 001 F 001 Non Compliance F686

Cross Reference POC for F686 The facility was out of compliance with the following state licensure requirements: 12 VAC 5-371-220 B Cross Reference to F695 This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 250 F +G cross reference to F Cross Reference POC for F695 656. 12 VAC 371-220 B - Cross Reference to 12 VAC 5 - 371 - 200 B - cross references to F F697 658. Cross Reference POC for F697 12 VAC 5 - 371 - 220 C1 - cross references to F 12 VAC 371-180 A - Cross Reference to F880 Cross Reference POC for F880 12 VAC 5 - 371 - 220 B - cross references to F 686. 12 VAC 371-140 Policy and Procedures Cross Reference to F550, F622, F623 12 VAC 5-371 - 220 B - cross references to F 695. Cross Reference POC for F550, F622, F623 12 VAC 5 - 371 - 220 B - cross references to F 12 VAC 371-150 Resident Rights Cross Reference to F550, F622, F623 Cross Reference POC for F550, F622, F623 12 VAC 5 - 371 - 180 A - cross references to F 880.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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continuation sheet 1 of 2

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
•	VA0108	B. WING	03/06/2019
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS CITY STATE ZIP CODE	

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HERITAG	ERITAGE HALL BLACKSTONE BLACKSTONE, VA 23824							
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	Continued From page 1  12VAC5-371-140. Policies and Procedures. Cross reference to F550, F622, F623  12VAC5-371-150. Resident Rights. Cross reference to F550, F622, F623.  12VAC5-371-360. Clinical Records. Cross reference to F622  Nursing Services 12VAC5-371-220 cross reference to F693  12VAC5-371-360. Clinical Records cross reference to F842. 12 VAC 5-371-250 (F) Cross Referenced to F-tag 657  12 VAC 5-371-220 (A) and (B) and (D) Cross Referenced to F-tag 689  12VAC5-371-110. Staff Treatment of Residents. Cross reference to F607 and F609.  12VAC5-371-140. Policies and Procedures. Cross reference to F609.	F 001						
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PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		495353	B. WING_	B. WING		·	06/2019	
NAME OF PI	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE			
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nerdiade	HALL BLACKSTONE			E	BLACKSTONE, VA 23824			
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					DEFICIENCY)			
E 000	Initial Comments	•	E	000				
F 000	survey was conducte 03/06/2019. The facil compliance with 42 C	ity was in substantial FR Part 483.73, <sub>I</sub> -Term Care Facilities.	F	000				
	survey was conducte Complaints were inve Corrections are requi CFR Part 483 Federa	dicare/Medicaid standard d 3/4/19 through 3/6/19. estigated during the survey. red for compliance with 42 al Long Term Care fe Safety Code survey/report						
F 550	148 at the time of the consisted of 45 curre closed record reviews	<del></del>	F	550	F550			
SS=E	CFR(s): 483.10(a)(1)  §483.10(a) Resident The resident has a right self-determination, as a coutside the facility, in this section.  §483.10(a)(1) A facility with respect and digresident in a manner promotes maintenance	Rights. ght to a dignified existence, and communication with and ad services inside and cluding those specified in  ty must treat each resident and in an environment that ce or enhancement of his or ognizing each resident's lity must protect and			Corrective Action(s): An Incident & Accident form was completed for the cafeteria style tray delivery for the residents in the cotta dining room. The staff involved in t tray delivery received one-on-one inservice training on the proper proof for delivery and set up of resident m trays in the dining room to provide a home-like dining experience.  C.N.A. #3 involved in feeding resident materials and Dignity regarding sitting not standing while providing feeding assistance to residents. A facility Inc. & Accident form has been completed.	age the cedure teal a tent and g		
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATURE	<u></u>		this incident.		(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

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	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495353	B. WING	B. WNG		C 03/06/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824			
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F 550	access to quality can severity of condition, must establish and m practices regarding to provision of services residents regardless.  §483.10(b) Exercise The resident has the rights as a resident or resident of the Unity of th	cility must provide equal e regardless of diagnosis, or payment source. A facility naintain 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 n, discrimination, or reprisal  esident has the right to be coercion, discrimination, and lity in exercising his or her orted by the facility in the r rights as required under this  T is not met as evidenced on, staff interview and facility was determined that the provide a dignified, homelike one of 3 facility dining dining room and failed to gnity during a meal for one of	F	550	Identification of Deficient Practice(and Corrective Action(s):  All other residents may have the potentially been affected. The Administrator and/or DON will assess dining experience and process for me delivery in all facility dining rooms to establish a formal tray set up, delivery feeding assistance process to ensure a staff are providing a dignified dining experience for all residents and provi appropriate assistance with their meat trays in a timely and appropriate man Systemic Change(s):  Facility policy and procedures were reviewed. No changes are warranted this time. The administrator, DON at Social Services will inservice all staff the facility policy and procedure regarding resident rights and dignity inservice will also cover the procedu proper meal tray delivery, set up and appropriate assistance to ensure all residents are served in a timely, dign and home-like manner.  Monitoring:  The DON and Administrator are responsible for compliance. The DO Administrator and/or designee will complete the 3 random meal pass au weekly to monitor for compliance. A negative findings will be corrected a time of discovery. The audit finding be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facili policy, procedure, or practice. Completion Date: April 17, 2019	s the al by and all ding l ner.  at ad/or f on  The re for  ified  N, dits All t the s will	

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Event ID: 82QJ11

Facility ID: VA0108

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 550	2. The facility staff in 86's dignity by stand providing assistant breakfast meal on 3. The findings included in 1. On 3/05/19 at 1: Cottage dining room lunch meal. There dining room when to time. The dining room when to time. The dining room when to attempt was made meals from the tray for a homelike dining. On 3/05/19 at 3:44 conducted with CNA Assistant), one of the residents. When as served their meals "That's how I've been asked if that is a cate experience, CNA #4 When asked what he they supposed to his setting." When ask being served on train not, I don't think so, that way on the other how they do it. I do different unit." When CNA #4 stated, "No A review of the facil Dignity" documente	ailed to respect Resident # ding next to her while e with feeding during the 3/6/19. e: 08 p.m., observation of the n was conducted during the were 27 residents in the he tray cart arrived at this om staff served all 27 I on the trays, cafeteria style. de to remove the residents' s and place them on the table	F 550			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING	CON	(X3) DATE SURVEY COMPLETED	
		495353	B. WING		1	C <b>/06/2019</b>
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP C 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	1	SHOULD BE	(X5) COMPLETION DATE
F 550	self-esteem and se specifically identify utilized for a dignifi experience.  On 3/05/19 at 5:07 Staff Member - The aware of the finding provided by the end 2. The facility staff 86's dignity by stan providing assistance. Resident # 86 was 04/17/15 with diagrant limited to: schiz bipolar disorder (3)  Resident # 86's moder (3)  86's moder (3)	ning and enhancing his or her elf-worth" The policy did not what style of dining should be ed, homelike dining  p.m., ASM #1 (Administrative e Administrator) was made gs. No further information was d of the survey. failed to respect Resident # ding next to her while e with feeding.  admitted to the facility on noses that included but were cophrenia (1), anxiety (2), and dysphagia (4).  est recent comprehensive MDS t) a quarterly assessment with ent reference date) of 01/12/19 as scoring a 6 (six) on the nental status (BIMS) of a score six) being severely impaired of decision making. Resident # otally dependent of one staff es of daily living. Resident # otally dependent of one staff	F	550		
***************************************	head of the elevate the floor. CNA (cer	ed and the bed lowered close to tified nursing assistant) # 3 ging in Resident # 86's	THE PARTY OF THE P			- Grand Andreas Andrea

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495353	B. WING		03	/06/2019	
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824			
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F 550	breakfast on a tray. breakfast tray on R table, opened all th over the bed in fron provided verbal pro 86 to try to feed her Resident # 86's bed	ge 4 CNA # 3 then placed the esident # 89's over-the-bed e containers moved the table at of Resident # 86 and ampts to encourage Resident # rself. While standing next to d, CNA # 3 provided total dent # 86 by feeding her the	F 5	50			
	conducted with CN. Resident # 86 was stated, 'Yes but she assistance to try an asked what her pos a resident with eatin be sitting down." W down while feeding CNA # 3 stated, "No wanted to get it dor important to sit nex	S a.m., an interview was A # 3. When asked if able to feed herself, CNA # 3 doesn't eat much so I provide a get her to eat more." When sition should be when assistinging, CNA # 3 stated, "I should then asked if she was sitting Resident # 86 her breakfast, o I didn't think about it. I just he." When asked why it is to or in front of a resident, CNA # 3 stated, "So you can em."					
	dated 01/12/9 docu NUTRITIONAL RIS DIAGNOSIS MECH RESTRICTIONS BI body weight) RANG intake." Under "Api "Provide diet as ord	e care plan for Resident # 86 mented, "Problem/Need. K DUE TO MULTIPLE IANICALLY ALTERED DIET ELOW NORMAL IBW (ideal SE. Swallowing issues. Poor proaches" it documented, lered. Monitor weight as and provide food preferences."					
	Is treated with cons recognition of his di	ent Rights" documented, "10. ideration, respect, and full gnity and individuality, treatment and in care for his					

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY IPLETED
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F 550	documented, "polis shall be cared for in enhances quality or individuality." Und Implementation" it dignity means the maintaining and errand self-worth. 12 impaired residents  The facility's policy documented, "3. F. Assistance: b. Resthemselves will be comfort and dignity over residents while over residents while on 03/26/19 at apple (administrative state administrator and acconsultant, were made of the consultant, were made of the consultant of the consult	"Quality of Life - Dignity" by Statement. Each resident in a manner that promotes and of life, dignity, respect and er "Policy Interpretation and documented, "2. 'Treated with resident will be assisted in inhancing his or her self-esteem. Staff shall treat cognitively with dignity and sensitivity."  "Assistance with Meals" Residents Requiring Full sidents who cannot feed fed with attention to safety, y, for example: (1) Not standing to assisting them with meals"  Proximately 3:30 p.m. ASM ff member) # 1, the ASM # 3, regional nurse hade aware of the findings.  Ition was provided prior to exit.  Iter that makes it hard to tell the in what is real and not real. This obtained from the website: a.gov/ency/article/000928.htm.  Irmation was obtained from the in.gov/medlineplus/anxiety.html	F	550			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353	B. WING		C 03/06/2019	
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F 550	carry out day-to-day obtained from the we https://www.nimh.nih order/index.shtml.  (4) A swallowing disc obtained from the we https://www.nlm.nih.gsorders.html.	y levels, and the ability to tasks. This information was absite: .gov/health/topics/bipolar-dis arder. This information was absite: gov/medlineplus/swallowingdi	F 550			
F 558 SS=D	CFR(s): 483.10(e)(3) §483.10(e)(3) The right services in the facility accommodation of repreferences except and endanger the health other residents. This REQUIREMENT by: Based on observation interview and clinical determined that the accommodation of residents in the survey. The facility staff failed call bell (a device with pushed to alert staff was within the residents in the residents in the survey.  The findings include Resident #89 was a 12/22/93 with a re-are residents in the residents.	ght to reside and receive y with reasonable esident needs and when to do so would or safety of the resident or  T is not met as evidenced on, staff interview, resident I record review, it was facility staff failed to provide esident needs for one of 51 rey sample, Resident # 89.  ed to ensure Resident # 89's th a button that can be when assistance is needed), ent's reach.	F 558	Resident #89's call bell was correct is now properly placed. CNA #3 winserviced on checking for the propplacement of resident call bell for #89. A facility Incident & Acciden was completed for this incident.  Identification of Deficient Practic Corrective Action(s): All other residents may have poter been affected. The DON, ADON unit managers will screen 100% or residents for proper call bell place and use to identify residents at risl is to include adaptive call bells. A negative findings identified will be corrected at the time of discovery An Incident and Accident form we completed for each negative finding.	as per resident at form sices & maially and/or fement k. This my/all be	

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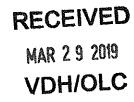
STATEMENT OF DEFICIENCIES (X1) PROVIDER'SUPPLIER'CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COMPLETED	
		495353	B. WING		03/06/2019
	ROVIDER OR SUPPLIER  HALL BLACKSTONE	=		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824	
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F 558	Parkinson's diseas Resident # 89's mo set), a quarterly as (assessment refere Resident # 89 as s interview for menta - 15, 3 (three) - bei cognition for makin 89 was coded as b staff member for ac G0400 "Functional coded Resident # 8 sides of her upper wrist, hand).  On 03/04/19 at ap observation of Res lying in bed, awake the bed was slight! Resident # 89's he bell's placement re on the left side of t could locate the ca unable to respond unintelligible speed On 03/05/19 at 3:0 Resident # 89 reve awake, neat and of was slightly raised head. Observation revealed it was ha just above the floor 89.	reflux disease (3) and e (4).  set recent MDS (minimum data sessment with an ARD ence date) of 01/16/19, coded coring an 3 (three) on the brief al status (BIMS) of a score of 0 ing severely impaired of ing daily decisions. Resident # seing totally dependent of one ctivities of daily living. Section I Limitation in Range of Motion" 89 as "No impairment" on both extremities (shoulder, elbow, proximately 7:00 p.m., an sident # 89 revealed she was a, neat and clean. The head of by raised and a pillow was under sad. Observation of the call evealed it was lying on the floor the bed. When asked if she sall bell Resident # 89 was to the request and verbalized ch  104 p.m., an observation of ealed she was lying in bed, clean. The head of the bed and a pillow was under her in of the call bell's placement inging off the left side of the bed or not within reach of Resident #	F 55	Systemic Change(s):  The facility policy and procedure been reviewed and no changes wat this time. All staff will be inset the DON on the proper placemer of resident call bells to ensure the properly placed within reach of a residents when in their rooms.  Monitoring:  The Unit Managers are responsite maintaining compliance. DON a Unit Managers will complete rate daily rounds throughout the day monitor for correct placement of to monitor for compliance. Any findings will be corrective at time discovery and disciplinary action taken as required. Aggregate find be reported to the QA Committee review, analysis, and recomment change in facility policy, proceed practice.  Completion Date: April 17, 26	arranted rviced by at and use ey are all  ble for and/or adom to f call bells negative ae of n will be dings will be for dations of lure, or
		33 a.m., an observation of ealed she was lying in bed,			

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Event ID: 82QJ11

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495353	B. WING _		03	C 9 <b>/06/2019</b>	
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP COD 900 S MAIN ST BLACKSTONE, VA 23824			
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F 558	head of the bed wa of the call bell reversivitch. Observation revealed it was harm just above the floor 89.  On 03/06/19 at 8:46 Resident # 89's cal conducted with CN. 3. When asked if the position that Reside activate sated, "It's describe the procedular bell for a resident Cobell for a resident Cobell should be checked time you go into the was in Resident # 8 CNA # 3 stated, "It's and set her up to fee think to check the composition of the consultant, were marked to a group of the consultant	ean, watching television. The s slightly raised. Observation aled it was a flat pressure n of the call bell's placement aging off the left side of the bed not within reach of Resident # 6 a.m., an observation of I bell placement was A (certified nursing assistant) # the call bell was placed in a sent # 89 could reach and not in reach." When asked to dure for the placement of a cell CNA # 3 stated, "They should for when they need you. Iften the placement of the call ked CNA # 3 stated, "Every the room." When asked if she so's room earlier that morning brought in tray for breakfast and I just didn't call bell."	F 55	8			
To state the state of the state		y originates before the age of					

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION			:ONSTRUCTION	(X3) DATE S COMPL	ETED		
		495353	B. WING_			03/0	6/2019
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	CH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
autism or causes, s responsive from the weather that the sease in the sease in the end of the end o	uch as lack eness. This vebsite:  w.report.ni spx?csid=1  of brain fu It affects in and behavior the widdineplus.com the windined from the www.nlm.nih.  of movem on was obtaw.nlm.nih.  Implement 483.12(b)(1)  b) The facinat written p  b)(1) Prohibit and exploit opriation of the composition of the	alsy, or from nonphysical of stimulation and adult is information was obtained in the gov/NIHfactsheets/ViewFa 100 inction that occurs with certain nemory, thinking, language, vior. This information was ebsite: gov/ency/article/000739.htm. is to leak back, or reflux, into irritate it. This information he website: gov/medlineplus/gerd.html. in the incent disorder. This ained from the website: gov/medlineplus/parkinsonsdi in Abuse/Neglect Policies (a) (3) lity must develop and olicies and procedures that: in the incent disorder is a procedure that in the incent develop and olicies and procedures that in the incent develop and olicies and procedures that in the incent develop and olicies and procedures that in the incent develop and olicies and procedures and resident property, olish policies and procedures uch allegations, and the training as required at	F	607	F607 Corrective Action(s): A facility Incident and Accident for completed for the resident to reside altercation and potential abuse between the resident #29 and resident #123 that not reported in the required 2-hour frame.	ent ween t was	

	DEFICIENCIES _ CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE : COMPL	
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	ROVIDER OR SUPPLIER  HALL BLACKSTONE		STREET ADDRESS, CITY, STATE, ZIP CODE  900 S MAIN ST  BLACKSTONE VA 23824				
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F 607	facility document revinvestigation of a Facility was determined that implement abuse pol reporting allegations 51 residents in the stand Resident #123.  The facility staff failed policy to ensure time Agency and other off resident altercation at Resident #29 and Resident #29 and Resident #29 and Resident #29 and Resident #29 was not reported untapproximately 16 ho occurred.  The findings included Resident #29 was at 3/12/15 with the diagonal cerebral vascular disdiabetes type 2, anx with hallucinations. Data Set (MDS) was an Assessment Reference and code cognitively impaired decisions. The resident hygiene, bathing, drumited assistance for of bowel and bladder Resident #123 was 5/29/12 with the diagonal resident #123	riew, clinical record review, iew, and in the course of an cility Reported Incident (FRI), at the facility staff failed to icies and procedures for of potential abuse for two of urvey sample; Resident #29 d to implement the abuse ly reporting to the State ficials of a resident to and potential abuse between esident #123 that occurred on ately 6:30 p.m. The incident ill 4/26/19 at 11:04 a.m., urs after the incident ill 4/26/19 at 11:04 a.m., are after the incident inc	F	607	Identification of Deficient Practices Corrective Action(s): All residents involved in resident to resident altercations may have been potentially affected. A 100% review Facility Incident & Accident Forms if the previous 60 days have been reviet to identify residents at risk for late reporting of resident to resident altercations with potential abuse allegations. Any/all negative finding be reviewed, and a facility Incident a Accident form will be completed for negative finding.  Systemic Change(s): The Policy & Procedure for reporting investigating abuse, neglect, misappropriation of resident propert injuries or unusual/unknown occurred has been reviewed. No changes are warranted at this time. All staff will inserviced and issued copies of the A and Investigation Policy and Proced These educational inservices will for prevention, identifying, reporting, an investigating incidents and allegation abuse, neglect or mistreatment of residents that are reported. The Administrator is responsible for completing internal investigations for reported incidents of unknown original abuse, neglect, unusual occurrences misappropriation of resident proper resident to resident altercations. The Administrator will review all findin verify that the appropriate notification the RP, attending physician and Stangencies was completed as indicate	of all for wed  s will and each  g and y and ences  be Abuse ure. cus on ad ans of  or all in, ty and e gs and ion to te	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING		PLE CONSTRUCTION  G	COMP	X3) DATE SURVEY COMPLETED C		
		495353	B. WING_	•		/06/2019
HERITAG	ROVIDER OR SUPPLIER  E HALL BLACKSTONE	STATEMENT OF DEFICIENCIES	10	STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824 PROVIDER'S PLAN OF CORRE		(x5)
(X4) ID PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG		OULD BE	COMPLETION DATE
F 607	recent MDS (Minimassessment with a Reference Date) of coded as being more make daily life decoded as requiring toileting, hygiene a assistance for transport of the transport of transport of the transport of transport of the transport of t	num Data Set) was an annual in ARD (Assessment of 1/16/19. The resident was oberately impaired in ability to isions. The resident was total care for dressing, and bathing; and limited sfers and eating.  (Facility Reported Incident) of 1/25/18 involving Resident #123 documented the facility at a commons are of the series of the o	F 6	Monitoring:  The Administrator is responsil compliance. All resident to resincidents, resident abuse and a allegations, unusual occurrence injuries of unknown origin withoroughly investigated, reported in the physicians and agencies as needed and imple disciplinary action for staff mean warranted. Confidential files reported incidents and all foll documentation will be maintated. Administrator's office. All in the thoroughly investigated. A findings will be reported to the Assurance Committee for reanalysis, and recommendation changes in policy, procedure facility practice.  Completion Date: April 17	sident neglect ces and Ill be rted to the appropriate ment members as of all low-up ained in the neidents will aggregate the Quality view, ons for the and/or	

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED		
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F 607	resident [Resident is hollered for name of up. Then name of while they were fight wall then name of [#7] were able to mapicked name of [Resident another CNA asked [Resident #123 and over there I helped of them said anything them are of them said anything and trying the sident #123]. Note that the statement documented, "Comfaicly how is faicly statement documented, "Comfaicly how is faicly statement and the sident #123]. Note that the statement faicly and trying the sident #123]. Note that the sident #123 is the sident #1	Resident #29] and name of #123] were fighting. So I of [CNA #6] and tried to break it [Resident #29] fell on the floor nting and hit his head on the CNA #6] and name of [CNA ake them stop fighting and esident #29] up off the floor."  I dated 4/25/18 by CNA #6 is coming down the hall when down the form the hall when down the hall when	F	607			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

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STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE ( COMPL	
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F 607	Continued From page	e 13	F	607		i	
		ied." When asked which					
		RI to the OLC, ASM #1				j	
	•	or, the DON (Director of					
	Nursing), the ADON	(Assistant Director of					
	Nursing) and the Ass	sistant Administrator."					
	In a follow up intervie	au on 3/7/10 at					
	•	o.m., with AMS #1, she					
	• • • • •	ther information and it was					
	my fault it was misse						
		y policy, "Abuse, Neglect and			•		
	Exploitation Preventi						
		dministrator, Director of		.			
	_ ,	pointed designee should					
	report allegations or exploitation immedia	suspected abuse, neglect or tely to:					
	ł T	Other state Agencies in					
	1	te LawIn response to					
	allegations of abuse	, neglect, exploitation or					
		cility must:Ensure that all					
	1 "	volving abuse, neglect,					
	•	eatment, including injuries of					
		re reported immediately, but					
	1	s after the allegation is made, use the allegation involve		1			
	E	nistrator of the facility and to					
	other official (includi						
		nce with State Law."					
	l .	on was provided by the end of					
	the survey.				F609		
F 609	. <u></u> Y			609	Corrective Action(s):	n was	
SS=D					A facility Incident and Accident for completed for the resident to residen	t	
		nse to allegations of abuse,			altercation and potential abuse between	een	
	neglect, exploitation	, or mistreatment, the facility			resident #29 and resident #123 that	was	

must:

frame.

not reported in the required 2-hour time

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 609	involving abuse, neg mistreatment, includi source and misappro are reported immedi hours after the allegated that cause the allegated serious bodily injury, the events that cause abuse and do not rethe administrator of officials (including to adult protective serv for jurisdiction in lon accordance with State procedures.  §483.12(c)(4) Report investigations to the designated represent accordance with State Survey Agency, with incident, and if the appropriate corrective This REQUIREMENT by:  Based on staff interfacility document retinvestigation of a Fait was determined the implement abuse por reporting allegations 51 residents in the stand Resident #123.  The facility staff fail to the State Agency	e that all alleged violations lect, exploitation or ing injuries of unknown opriation of resident property, ately, but not later than 2 ation is made, if the events ation involve abuse or result in or not later than 24 hours if e the allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ices where state law provides geterm care facilities) in the law through established  It the results of all administrator or his or her intative and to other officials in the law, including to the State hin 5 working days of the alleged violation is verified by action must be taken.  It is not met as evidenced  It is not met as evidenced	F	609	Identification of Deficient Practice & Corrective Action(s):  All residents may have been potent affected. A 100% review of all Fa Incident & Accident Forms for the previous 60 days have been review identify residents at risk. Any/all negative findings of reportable occurrences identified will result in internal investigation with appropring notification of outcomes to the State agencies, attending physician and responsible parties.  Systemic Change(s):  The facility Policy and Procedure reporting resident abuse & neglect been reviewed and no changes are warranted at this time. All facility administrative staff will be inservithe facility Abuse prevention and reporting policy and procedures reporting, investigation and propenotification to state agencies of allegations of abuse, neglect, misappropriation of resident propinjuries of unknown origin and reresident altercations by the Region Nurse Consultant. All facility staff inserviced on the Abuse prevention investigation and reporting policy procedure. These educational insemil focus on prevention, identify reporting and investigating incide allegations of abuse, neglect or mistreatment of residents, resident resident altercations and misapprof property that are reported. The Administrator is responsible for completing internal investigation reported incidents of injuries of uncompleting internal investigation.	tially cility yed to an an iate te for has ceed on egarding r erty, sident to nal f will be on, and ervices ing, ents and at to opriation s for all	

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F 609	procedures for a resi and potential abuse Resident #123 that of approximately 6:30 preported to the State 11:04 a.m., approximincident occurred.  The findings include Resident #29 was an 3/12/15 with the diag cerebral vascular disidiabetes type 2, anx with hallucinations. Data Set (MDS) was an Assessment Refe 12/14/18, and coded cognitively impaired decisions. The resid hygiene, bathing, dr limited assistance for for bowel and bladded Resident #123 was 5/29/12 with the diad dementia, depression recent MDS (Minimal assessment with an Reference Date) of coded as being more make daily life decisioned as requiring to ideting, hygiene and assistance for transit	dent to resident altercation between Resident #29 and occurred on 4/25/19 at o.m. The incident was not a Agency until 4/26/19 at nately 16 hours after the denitted to the facility on gnoses of but not limited to sease, high blood pressure, itety, depression, psychosis Resident #29's Minimum as a quarterly assessment with erence Date (ARD) of desident #29 as severely in ability to make daily life lient required total care for easing, ambulation, transfers; or eating; and was incontinent er.  admitted to the facility on gnoses of but not limited to on, and asthma. The most of the properties of the pro	F	609	origin, abuse, neglect, unusual occurrences, misappropriation of res property and resident to resident altercations. The administrator will review all findings and verify that the appropriate notification to the RP, attending physician and State agenciewas completed as indicated.  Monitoring:  The Administrator is responsible formaintaining compliance. All Facility Incident & Accidents forms will be reviewed daily by the Administrator ensure any reportable items are investigated and reported as required Confidential files of reported incide and all follow-up documentation with maintained in the Administrator's of The Risk Management Committee review I&A Reports to identifying correcting negative patterns of commercial megative findings will reported and investigated. Aggregifindings will be reported to the Quantysis, and recommendations for changes in policy, procedure, and/of facility practice.  Completion Date: April 17, 2019	r to  d.  ents ill be office.  will  and/or upletion be ate ality	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 "		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 609	#29] and name of name of [CNA #5] residents were locunit 400. Name of and fell hitting the The residents were head to toe assess (Licensed Practica #123] was found to the back of his need does not have any residents deny pai [responsible party Both residents were checks for 48 hour have been no furth investigation is in proflow."	6:30 p.m., name of [Resident [Resident #123] were seen by swinging at each other. The ated in the commons are of [Resident #29] lost his balance back of his head on the wall. It immediately separated. A swas done by name of LPN #7 Nurse). Name of [Resident of have two small scratches on the common than the common than and medical doctor] are aware. The place on Q [every] 15 minute the place on Q [every] 15 minute the common than the common to the place on the common to the place on the place of	F6	09			
	documented, "I caname of resident [resident [Resident hollered for name of up. Then name of while they were figwall then name of #7] were able to mpicked name of [Resident hollered]. "I was a written statement documented, "I was a written statement hollered]." I was a written statement hollered.	t dated 4/25/18 by CNA #5 me around the corner and Resident #29] and name of #123] were fighting. So I of [CNA #6] and tried to break it [Resident #29] fell on the floor hting and hit his head on the [CNA #6] and name of [CNA ake them stop fighting and esident #29] up off the floor."  t dated 4/25/18 by CNA #6 s coming down the hall when d me for help with names of		-			

AND PLAN OF CORRECTION   IDENTIFICATION NUMBER:   (X2) MULTIPLE CONSTRUCTION   A. BUILDING			COMPLETED			
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F 609	[Resident #123 and over there I helped of them said anyth A written statement documented, "Con sic) how is sic) st for another CNA. of [Resident #29] v [Resident #123]. Now the feet of t	d Resident #29]. When I got get them apart. Neither one ing."  It dated 4/25/18 by CNA #7 ning back on unit, dont {sic} no arted. Name of [CNA #5] call Then I came around and name was punching name of Iame of [Resident #123] was to pull is {sic} arm away from #29] and we separted {sic} the [Resident #29] off floor. Name just told name of [Resident ell a loose."  The FRI revealed that on mately 11:04 a.m., the facility e Office of Licensure (OLC) as onfirmation report.  The p.m., with the ASM #1 off Member, the Administrator). If the reporting date and time of tated, "I don't have an answer nest with you. Let me look to tified." When asked which FRI to the OLC, ASM #1 isor, the DON (Director of N (Assistant Director of ssistant Administrator."  Wiew on 3/7/19 at p.m., with AMS #1, she urther information and it was		09		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII			(X3) DATE SURVEY COMPLETED		
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F 609	Nursing or facility ap report allegations or exploitation immedia AdministratorOLC. accordance with Star allegations of abuse, mistreatment, the facility alleged violations invexploitation or mistre unknown sourcear not later than 2 hour if the events that cau abuseto the admin other official (including Agencyin accordance).	on and Reporting" dministrator, Director of pointed designee should suspected abuse, neglect or tely to:Other state Agencies in te LawIn response to , neglect, exploitation or cility must:Ensure that all volving abuse, neglect, eatment, including injuries of e reported immediately, but s after the allegation is made, use the allegation involve istrator of the facility and to ng the State Survey	F	609				
F 622 SS=E	CFR(s): 483.15(c)(1 §483.15(c) Transfer §483.15(c)(1) Facility (i) The facility must premain in the facility discharge the reside (A) The transfer or corresident's welfare and cannot be met in the (B) The transfer or corresident in the control of	and discharge- y requirements- permit each resident to , and not transfer or ent from the facility unless- lischarge is necessary for the nd the resident's needs a facility; discharge is appropriate nt's health has improved asident no longer needs the y the facility; dividuals in the facility is the clinical or behavioral	F	622	Corrective Action(s): The facility staff failed to ensure comprehensive care plan goals w submitted to the receiving hospit Residents #38, #45, #95, #137, # #153 when transferred to the hos facility Incident & Accident Forn been completed for each resident involved.  The facility staff failed to provide receiving Hospital with the apprinformation when transferring re #92 to the hospital to include, the attending physician contact information, resident and comprease plan goals for Resident #92	ere al for 141 and pital. A n has tethe opriate esident e mation, whensive		

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C				
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F 622	(D) The health of indicate otherwise be endang (E) The resident has appropriate notice, to under Medicare or M Nonpayment applies submit the necessary payment or after the Medicare or Medicair resident refuses to president who become admission to a facility resident only allowate or (F) The facility cease (ii) The facility may be resident while the aps 431.230 of this charge notice fror 431.220(a)(3) of this discharge or transfer or safety of the resident under any of the facility. The facility resident under any of in paragraphs (c)(1) section, the facility ror discharge is documedical record and communicated to the institution or provide (i) Documentation in must include:	viduals in the facility would ered; failed, after reasonable and pay for (or to have paid edicaid) a stay at the facility. if the resident does not a paperwork for third party third party, including a denies the claim and the pay for his or her stay. For a less eligible for Medicaid after and the facility may charge a sole charges under Medicaid; as to operate. The facility may charge the peal is pending, pursuant to paper, when a resident right to appeal a transfer or in the facility pursuant to a chapter, unless the failure to be would endanger the health ent or other individuals in the must document the danger for or discharge would pose.  The facility pursuant to service of the circumstances specified (i)(A) through (F) of this must ensure that the transfer mented in the resident's appropriate information is a receiving health care	F	622	Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may hav been affected. The DON, ADON and Unit Managers will conduct a 100% of all residents who have been dischard and/or transferred from the facility in past 30 days to identify residents that not have the required documentation submitted to the receiving facility. A facility Incident & Accident Form we completed for each negative finding.  Systemic Change(s): Facility policy and procedures have reviewed. No revisions are warrante this time. The DON and/or Regiona Nurse Consultant will inservice facil licensed staff on the documentation required to be submitted to the receive facility when a resident is being transferred or discharged to the hosp other outside health care facility.  Monitoring: The DON/designee will be responsible maintaining compliance. The DON a designee will conduct chart audits we of all residents who have been dischard/or transferred from the facility to monitor for compliance. Any/all neglindings and or errors will be correct time of discovery. Aggregate finding these audits will be reported to the Quality Assurance Committee quart for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: April 17, 2019	e d/or audit arged a the t did  ill be been d at l ity ving ital or  ble for and/or cekly arged o gative ted at gs of erly	

Facility ID: VA0108

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HERITAC	GE HALL BLACKSTO	NE		900 S MAIN ST BLACKSTONE, VA 23824			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 622	(i) of this section. (B) In the case of p section, the specific be met, facility atterneeds, and the service facility to meet the resident (2)(i) of this section (A) The resident's p discharge is necess (A) or (B) of this section (B) A physician when ecessary under pathis section. (iii) Information promust include a mini (A) Contact informat responsible for the (B) Resident representact information (C) Advance Direct (D) All special instruction (C) Advance Direct (D) All special instruction (F) All other necessary of the resident consistent with §48 any other documen a safe and effective This REQUIREMENT by:  Based on staff interned and facility docume failed to evidence a provided to the recefacility initiated transports.	aragraph (c)(1)(i)(A) of this cresident need(s) that cannot mpts to meet the resident vice available at the receiving need(s). Sion required by paragraph (c) must be made byolysician when transfer or sary under paragraph (c) (1) ction; and en transfer or discharge is aragraph (c)(1)(i)(C) or (D) of vided to the receiving provider mum of the following: stion of the practitioner care of the resident. Sentative information including vive information uctions or precautions for oppopriate. Sary information, including a t's discharge summary, 3.21(c)(2) as applicable, and tation, as applicable, to ensure e transition of care.  NT is not met as evidenced rview, clinical record review nt review, the facility staff II required documentation was serving facility at the time of a sfer, for seven of 51 sampled ints #95, #141, #137, #45,	F				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTI		(X3) DATE SURVEY COMPLETED	
		495353	B. WING				C <b>/06/2019</b>
	PROVIDER OR SUPPLIER GE HALL BLACKSTO		L.,	900 S MAII	DDRESS, CITY, STATE, ZIP CODE N ST TONE, VA 23824		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD OSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 622	<ol> <li>The facility staff comprehensive ca were provided to the resident was transful 1/11/19.</li> <li>The facility staff comprehensive cawere provided to the resident was transful 1/13/18, 12/23/18.</li> <li>The facility staff comprehensive cather that occurrent and the transfer on 02/4.</li> <li>The facility staff facility with the Rescare plan goals for transfer that occurrent and the tran</li></ol>	failed to evidence that the re plan goals for Resident #95 he receiving facility when the ferred to the hospital on failed to evidence that the re plan goals for Resident #141 he receiving facility when the ferred to the hospital on and 1/23/19.  If failed to evidence that re plan goals for Resident # the resident to the hospital for 19/19.  If failed to provide the receiving sident #45's comprehensive a facility initiated hospital red on 11/25/18.  If failed to evidence that the re plan goals for Resident #153 he receiving facility when the ferred to the hospital on failed to provide evidence that fation (including physician he, resident representative he, special instructions for ance directives and re plan goals) was provided to hen Resident #92 was	F	22			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
		495353	B. WING		***************************************		С
		495353	D. WING			03/	06/2019
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 622	}	y when Resident #38 was	F	322			
	The findings includ	e:	en menenen en				Average and Averag
	comprehensive car were provided to th	failed to evidence that the re plan goals for Resident #95 re receiving facility when the erred to the hospital on					
	1/26/17 with the dia not limited to atrial with behaviors, bipe and dysphagia. The Data Set) was a sig with an ARD (Asse 1/25/19. The resid cognitively impaired decisions. The res	admitted to the facility on agnoses that included, but are fibrillation, stroke, dementia plar disorder, anxiety disorder, e most recent MDS (Minimum gnificant change assessment essment Reference Date) of ent was coded as severely d in ability to make daily life ident was coded as requiring eas of activities of daily living.					
	note dated 1/11/19 documented, "Resi discoloration to left assessed by super to be found. Provid to send patient to E evaluation. RP (remessages left for trupdates. (Name of transport and is (Name of hospital) (name of ER staff).	ical record revealed a nurse's at 11:24 a.m. that dent reported to have lower extremity. Resident visor and pedal pulses unable der called and order obtained in (emergency room) for sponsible party) called and wo contacts to call back for a county) called for emergency to unable to understand reason unable to sign bed hold form. ER called and given report to (Name of county ambulance) and at 10:33 am to (name of					

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		495353	B. WING		0.5	C 3 <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		10012010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	/IDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 622	hospital) ER."  Further review of the reveal what docume hospital.  On 3/06/19 at 2:04 conducted with LPN Nurse), the unit males stated that where hospital, the facility facesheet, one for the resident's Historecord, last recertificates, Medication Act transfer form, and the When asked about goals, LPN #8 states plan." When asked transfer form. LPN name, date time, when address, phone for sending them, the checklist; it is in a pout." LPN #8 provices hecklist. A review Resident To The Heinclude that compresse provided.  The facility policy, "Emergency" was reinclude requirement including comprehends be provided to the incompresse provided	de clinical record failed to centation was provided to the common was provided to the sends 2 copies of the common was progress of the common was progress not and progress not progress progress not progress progress not pr	F 6:			

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495353	B. WING			1	06/2019
	PROVIDER OR SUPPLIER			9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 S MAIN ST BLACKSTONE, VA 23824	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 622	Continued From pa provided by the en	-	F	622			
	comprehensive ca were provided to the	failed to evidence that the re plan goals for Resident #141 ne receiving facility when the ferred to the hospital on and 1/23/19.					
	8/7/14 with diagnor limited to dementia psychotic disorder delusions, anxiety obstructive pulmor aneurysm, Parkins hyperplasia, ileus, recent MDS (Minin readmission asses (Assessment Refe	s admitted to the facility on sees that include but are not a with behaviors, psychosis, with hallucinations and disorder, glaucoma, chronic nary disease, abdominal aortic onism, benign prostatic and dysphagia. The most num Data Set) was a 30 day asment with an ARD rence Date) of 3/6/19. The d as being mildly impaired in y life decisions.					
	A review of the clin following:	ical record revealed the	CONTROL OF THE PROPERTY AND THE PROPERTY				
	note dated 1/23/19 the nursing station transports resident service at 7 pm station room and resident drooling allover (signification) immediately went to noted to be slouch wheelchair and dro mouthNurse cal couple of times wit	8/19 hospitalization: A nurse's documented, "Nurse was at when the gentleman that is across the street for church ates that he went in resident's was unresponsive and by himselfcharge nurse to evaluate resident. Resident ed over to the right side of his bool dripping from led out resident's name a h no response so then nurse ul sternal rub again no					

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

Event ID: 82QJ11

Facility ID: VA0108

If continuation sheet Page 25 of 131

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MAR 2 9 2019

VDH/OLC

	OF CORRECTION	IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	COM	E SURVEY IPLETED
		495353	B. WING			į.	C <b>06/2019</b>
	PROVIDER OR SUPPLIER			90	REET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST LACKSTONE, VA 23824	1 00	
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F 622	stimulation verball residentSupervi doctor) to make as Order obtained to for further evaluati resident upon nurs face droop presen unable to speak al onset. Symptoms (emergency medic resident via stretch further evaluation  Regarding 12/23/1 note dated 12/23/1 CNA (certified nurs writer of rectal blee moderate amount clots oozing from resident to acute of the control of t	y or physically from sor contacted MD (medical ware of resident's condition. send to ER (emergency room) onCharge nurse stayed with sing assessment right sided it, both pupils fixed, resident I these symptoms are new appear to be stroke likeEMS all service) arrived to transport her to (name of hospital) for"  8 hospitalization: A nurse's 8 documented, "At 5:30 am sing assistant) notified this edding; upon assessment: dark red blood, mixed with ectum; blood continued to ooze eansedorder given to transfer are"  8 hospitalization: A nurse's 8 documented, "Resident to (hospital) via ambulance for f possible ileus and lent started with cold symptoms ich led to a chest x-ray to rule he chest x-ray suggested eus, MD (medical doctor) made ed KUB (Kidney, Ureter, vestigate since resident had two on the 11th. KUB performed for results on the 13th, verbal ositive for colonic ileus, possible inormal gas pattern. MD obtained to send to hospital for	F	522			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			СОМ	(X3) DATE SURVEY COMPLETED C	
		495353	B. WING	·····		i .	06/2019
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, Z 900 S MAIN ST BLACKSTONE, VA 23824	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 622	Further review of the reveal what docume hospital for each of On 3/06/19 at 2:22 #1 (Registered Nur Resident #141), who sent to the hospital transfer packet, face right down the check comprehensive car stated, "We do not A review of the "What The Hospital" check comprehensive car provided.  The facility policy, "Emergency" was reinclude requirement including comprehensive provided to the recomprehensive car 137 Mere sent with the transfer on 02/11 Resident # 137 was 01/08/2017 with a rediagnoses that inclusepsis (1), gastrost	ne clinical record failed to entation was provided to the the above hospitalizations.  p.m., in an interview with RN se, the unit manager for the asked what paperwork is the stated, "We send the se sheet, immunizations, we gooklist." When asked if the se plan goals are sent, RN #1 send the care plan goals."  Then Sending A Resident To klist failed to include that the plan goals must be  Transfer or Discharge, eviewed. The policy did not the sof what documentation, ensive care plan goals, must receiving facility.  p.m., ASM #1 (Administrative Administrator) was made gs. No further information was did of the survey.  failed to evidence that the plan goals for Resident # the resident to the hospital for	F6	322			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495353	B. WING _		03	C <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP COD 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 622	data set), a quarter (assessment refere Resident # 137 as a assessment for me of 0 - 15, 3(three) - cognition for making. The nurse's "Progrefor Resident # 137 rounds this shift (2/(increased) audible (right bronchial) [lur in all lung fields. V3 (temperature), 189/pressure). Pulse w Tylenol elixir 20.3 c (tube feeding) giver (temperature) with a (Pulse oximetry) 88 L/nc (liters by nasal 4l?nc. NP (nurse perecitioner) notifies resident out to [sic] room) for evaluation (Name of Responsi stated she would denotified and in to p/(12:15 a.m.), [sic] no (increased) to 95% squad left facility with Hospital) via stretch was called back and sent to (Name of Hoknow if resident will Review of the clinica "Resident # 137 failed the sent to the clinica "Resident # 137 failed the sent to the clinica" Resident # 137 failed the sent to the clinica "Resident # 137 failed the sent to the clinica" Resident # 137 failed the sent to the clinica "Resident # 137 failed the sent to the clinica" Resident # 137 failed the sent to the clinica "Resident # 137 failed the sent to the clinica" Resident # 137 failed the sent to the clinical "Resident # 137 failed the sent to the clinical "Resident # 137 failed the sent to the clinical "Resident # 137 failed the sent to the clinical "Resident # 137 failed the sent to the clinical "Resident # 137 failed the sent to the clinical "Resident # 137 failed the sent to the clinical "Resident # 137 failed the sent to the sen	nce date) of 02/14/19, coded scoring a 3 (three) on the staff ntal status (BIMS) of a score being severely impaired of	F 62			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495353	B. WING		03	C <b>/06/2019</b>
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP COD 900 S MAIN ST BLACKSTONE, VA 23824		700/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 622	Hospital) upon the toon 3/06/19 at 2:04pc conducted with LPN Nurse), the unit ma #8 stated that when hospital, the facility facesheet, one for to the resident's Historic record, last recertificates, Medication Addition and the transfer form, and to the When asked about goals, LPN #8 states plan."  The facility policy, "Emergency" was resinclude requirement including comprehes be provided to the roon 03/06/19 at approposition (administrator and A consultant, were made to the provided to the roon of the transfer forms. The symptom of the germs thems body releases causinformation was obto https://medlineplus.	rransfer of Resident # 137.  o.m., an interview was I #8 (Licensed Practical nager for Resident #95. LPN the resident goes to the sends 2 copies of the ransport and one for hospital, ry and Physical, immunization cation, last progress note, ministration Record, the he bed hold policy agreement. The comprehensive care planted, "We do not send the care Viewed. The policy did not to so what documentation, insive care plan goals, must eceiving facility.  Troximately 3:30 p.m. ASM	F 6	522		

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	OF CORRECTION	IDENTIFICATION NUMBER:	1	IG		E SURVEY IPLETED
		<b>49</b> 5353	B. WING _		1	C <b>06/2019</b>
	PROVIDER OR SUPPLIER	<b>VE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 622	the stomach wall. It stomach. This inforwebsite: https://medlineplus.  (3) Also called: Hen Quadriplegia. Parafunction in part of your something goes wro pass between your can be complete or both sides of your bone area, or it can be	ling tube through the skin and goes directly into the mation was obtained from the gov/ency/article/002937.htm.  niplegia, Palsy, Paraplegia, lysis is the loss of muscle our body. It happens when ong with the way messages brain and muscles. Paralysis partial. It can occur on one or ody. It can also occur in just be widespread. This ained from the website:	F 62			
	facility with the Resi care plan goals for a transfer that occurre Resident # 45 was a 07/29/14 and a re-a diagnoses that inclu- retention of urine, un benign prostatic hyp (3) and hypertension recent MDS (minimal assessment with an date) of 12/19/18, co scoring a 9 (nine) or status (BIMS) of a s moderately impaired decisions.	failed to provide the receiving dent #45's comprehensive a facility initiated hospital ed on 11/25/18.  Admitted to the facility on dmission on 11/30/18 with ded but were not limited to: rinary tract infection (1), perplasia (2), diabetes mellitus in (4). Resident # 45's most um data set), a 30-day  ARD (assessment reference oded Resident # 45 as in the brief interview for mental core of 0 - 15, 9 (nine) - being d of cognition for making daily				

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		495353	B. WING			C <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTON	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 622	end of evening shift (resident) was again refused both. Total (approximately) 120 much effort. Res cowant any water or ju- (to) 100 cc cloudy colostomy bag this when asked. At 220 practitioner) (Name and gave verbal ord hospital ER (emergrule out possible bosupervisor was maccontact RP (responsionated RP (responsionated RP (responsionated RP (remains and pave verbal ord hospitals) we by EMT (emergency (Name of Transport of two Hospitals) we by EMT (emergency (Name of Hospital) had no available be with possible transfeleft with res en route 2345 (11:45 p.m.)."  Review of the facility dated 11/25/18 for F documentation that to (Name of Hospital Resident # 45.  On 3/06/19 at 2:04p conducted with LPN Nurse), the unit mar #8 stated that when hospital, the facility facesheet, one for to the resident's History the state of the resident's History the resident history the residen	ge 30 11:53 p.m. documented, "At (2200) [10:00 p.m.] res offered water and juice, intake for shift was approx. Occ (cubic centimeters), with ont (continues) to say "I don't vice." Foley (catheter) 0 (zero) amber urine, no stool in shift. Res denies any pain 30 (10:30 p.m.) NP (nurse of Nurse Practitioner) notified ler to send resident out to ency room) for evaluation to wel obstruction. Night le aware. Attempts made to sible party) on all 3 numbers. Is squad in, stated both (Name ere on diversion. Call placed of medical technician) to ER nurse, who stated they dis but would accept resident er to another hospital. Squad er to (Name of Hospital) at the care plan goals were sent all upon the transfer of the care plan goals were sent all upon the transfer derivation. In an interview was all (Licensed Practical mager for Resident #95. LPN the resident goes to the sends 2 copies of the ransport and one for hospital, y and Physical, immunization cation. Last progress note.	F 6	22		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495353	B. WING		03	C <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824		,00,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 622	labs, Medication Ad transfer form, and to When asked about goals, LPN #8 state plan."  The facility policy, "Emergency" was reinclude requirement including comprehe be provided to their On 03/06/19 at application (administrative staff administrator and A consultant, were made administrator and A consultant, were made administration was obton the consultant of the consul	Iministration Record, the he bed hold policy agreement. the comprehensive care planed, "We do not send the care  Transfer or Discharge, viewed. The policy did not to sof what documentation, insive care plan goals, must eceiving facility.  Troximately 3:30 p.m. ASM member) # 1, the SM # 3, regional nurse ade aware of the findings.  This ained from the website:  "gov/medlineplus/ency/article/"	F	is 22		
-	obtained from the w					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		495353	B. WING		03	C <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	<b>VE</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 622	essure.html.  5. The facility staff f comprehensive care were provided to the resident was transfe 2/15/19.  Resident #153 was 9/13/16. Diagnoses but are not limited to disturbances, bipolar pressure, and asthmatical Data Set (MDS) was status assessment. Reference Date (AFResident #153 as as skills for daily decision of the clinic note dated 2/15/19 and spoke with mode (regarding): transfer appropriate setting fother, and order writhospital) er (Emerge (psychiatric) eval (evadmission re: behave (message) for rp (Resident #150 spoke) admit to hoprevious behaviors, 'okay.' at 1150 spoke)	ailed to evidence that the e plan goals for Resident #153 e receiving facility when the erred to the hospital on admitted to the facility on a for Resident #153 included to dementia with behavioral ar disorder, high blood na. Resident #153's Minimum as a significant change in with an Assessment RD) of 1/15/19, and coded everely impaired for cognitive on-making.  Cal record revealed a nurse's at 12:45 p.m., that inconitoring has continued since at 1140-(Name of Doctor) in	F 6	22		
	transport resident to	(Name of hospital) er. at				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	TIPLE CONSTRUCTION  NG	СОМ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER GE HALL BLACKSTOI	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824	1 005	00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 622	ambulance) in facili (Name of hospital) given to (name of E at (Name of hospital).  Further review of th reveal what docume hospital.  On 3/06/19 at 2:04pconducted with LPN Nurse), the unit mai #8 stated that when hospital, the facility facesheet, one for t the resident's Historecord, last recertification Ad transfer form, and the When asked about goals, LPN #8 state plan."  The facility policy, "The facility policy, "Emergency" was reinclude requirements."	ty and enroute via stretcher to er at 1235. at 1242 report was R staff) rn (Registered Nurse) all) er."  e clinical record failed to entation was provided to the entation entation entation goes to the entation entation, last progress note, entation entation entation entation entation entation entation entation.  Transfer or Discharge, eviewed. The policy did not its of what documentation, ensive care plan goals, must	F6			
	(Administrative Staf was made aware of	rimately 6:26 p.m., AMS #1 f Member - the Administrator) the findings. No further vided by the end of the				
	all required information,	ailed to provide evidence that ion (including physician resident representative special instructions for				

AND PLAN OF CORRECTION   (X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:		1 '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495353	B. WING	i <u>.</u>		1	C (06/0010
	PROVIDER OR SUPPLIER GE HALL BLACKSTO			S1 90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST BLACKSTONE, VA 23824	US/	06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 622	ongoing care, adva comprehensive can the hospital staff wh transferred to the hospital staff wh transferred to the hospital staff whospital staff whospital staff were not limited to be cholesterol and commost recent MDS (rassessment with ar date) of 1/18/19, cocognitively intact.  Review of Resident the resident present and was transferred. Further review of Resident the facility staff information to hospital transferred with LPN and RN (registered #1 were asked to deprovided to hospital transferred to the hoppowides physician ox-rays, a history and record and face she does not provide co	unce directives and re plan goals) was provided to hen Resident #92 was		622	DEFIGENCY)		
ANALYZA A PARTICIPA PARTIC	with instructions and stated a copy conta check off list is sent placed in the reside	d a check off list. RN #1 aining all the information on the t to the hospital and a copy is ent's clinical record. RN #1 for sending information to the	de de des de la companya de la compa				

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	DING		(X3) DATE SURVEY COMPLETED	
		495353	B. WING			C <b>3/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824		3/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
F 622	last year and the prhe was not sure if the Resident #92 was to the could not provide evinformation was proceed to the first terms of the above to the receiving facility transferred to the horse to the sure of tissue by bacteria infection) (1). The modata set) assessment to the was not supported to the proceed to the pro	evised multiple times over the ocess was recently revised so his process was in place when ransferred to the hospital.  I.m., RN #1 confirmed he widence that the required evided to hospital staff when ransferred to the hospital on the hos	F 6	;22		
The state of the control of the state of the	documented in part, Res (resident) reste	ted 11/10/18 at 2:02 a.m. "Late entry for evening shift - d well in bed, IV (intravenous) i) infusing in rt (right)				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495353	B. WING			C / <b>06/2019</b>	
	PROVIDER OR SUPPLIER  GE HALL BLACKSTOR	NE .		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		.00.2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 622	at supper, only ate a party) in to visit. Atte for (Name of Hospit and decreased intal record failed to reve evidencing what inforeceiving hospital at transfer on 11/10/19. On 3/06/19 at 2:04p conducted with LPN Nurse), the unit mar #8 stated that when hospital, the facility facesheet, one for to the resident's Histor record, last recertificates, Medication Additransfer form, and the When asked about	n increased coughing episode a few bites. RP (responsible endants in to pick up resident al) for evaluation of lethargy ke." Review of the clinical eal any documentation prmation was provided to the the time of the residents	F 62				
William Commission of the Comm	administrator, ASM consultant, and ASM president of operation	member (ASM) #1, the #3, the regional nurse 1 #4, the regional vice ons, were made aware of the 6/19 at approximately 6:00					
Terraman ann ann ann ann ann ann ann ann ann		on was obtained prior to exit.					
	Non-Medical Reade Chapman, page 527	s Before Transfer/Discharge	F 62	23			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
•		495353	B. WING		······	03/0	) 06/2019
	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	9 E	TREET ADDRESS, CITY, STATE, ZIP CODE  00 S MAIN ST  BLACKSTONE, VA 23824  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR	3E	(X5) COMPLETION DATE
F 623	the reasons for the manguage and manner facility must send a corepresentative of the Long-Term Care Om (ii) Record the reason discharge in the residuaccordance with para and (iii) Include in the not paragraph (c)(5) of the \$483.15(c)(4) Timing (i) Except as specific (c)(8) of this section, discharge required unade by the facility a resident is transferrer (ii) Notice must be made before transfer or dis (A) The safety of ind be endangered under this section; (B) The health of ind be endangered, und this section; (C) The resident's heallow a more immed under paragraph (c) (D) An immediate trarequired by the residents.	before transfer.  fers or discharges a nust- and the resident's he transfer or discharge and nove in writing and in a er they understand. The topy of the notice to a Office of the State budsman. Ins for the transfer or dent's medical record in agraph (c)(2) of this section;  ice the items described in his section.  I of the notice. I din paragraphs (c)(4)(ii) and the notice of transfer or nder this section must be at least 30 days before the d or discharged. I add as soon as practicable	F	623	F623 Corrective Action(s): Resident #141's responsible party heen notified that the facility failed provide a discharge/transfer notice fresident's transfer to the hospital on 12/23/18.  Resident #45 and their responsible phas been notified that the facility failed provide a discharge/transfer notice resident's transfer to the hospital on 11/25/18.  Resident #153's responsible party heen notified that the facility failed provide a discharge/transfer notice resident's transfer to the hospital or 2/5/19.  Resident #92 and their responsible has been notified that the facility failed provide a discharge/transfer notice resident's transfer to the hospital or 10/3/18.  Resident #38 and their responsible has been notified that the facility failed provide a discharge/transfer notice resident's transfer to the hospital or 11/9/18.	cor the coarty cled to for the cas to for the cas for the cas are cast to for the cast to for	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495353	B. WING			03/0	06/2019
	E HALL BLACKSTONE	4		900	REET ADDRESS, CITY, STATE, ZIP CODE  S MAIN ST  ACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	substitute of the protection and developmental disabilities, the mailitelephone number of the protection and adevelopmental disabilities, the mailitelephone number of the protection and a developmental disabilities and substitute of the Developmental disabilities and developmental disabilities and substitute of the Developmental disabilities and substitute of the Developmental disabilities and sub	ants of the notice. The written aragraph (c)(3) of this section owing: ansfer or discharge; an fransfer or discharge; an fransfer or discharge; an fransfer or discharge; and transfer or discharge; and the resident is anged; are resident's appeal rights, address (mailing and email), and information on how form and assistance in and submitting the appeal ass (mailing and email) and and the Office of the State abudsman; and email address and and email address and and email address and and the agency responsible for and dovocacy of individuals with a milities established under Part antal Disabilities Assistance at of 2000 (Pub. L. 106-402, and ality residents with a mental alisabilities, the mailing and alelephone number of the for the protection and als with a mental disorder are Protection and Advocacy duals Act.	F	623	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 conduct a 100% audit of all resident have been discharged and/or transfe in the past 60 days. Residents identirisk will be corrected at time of disc and the required notifications to the residents' responsible party and the ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding.  Systemic Change(s): Facility policy and procedures have reviewed. No revisions are warranthis time. The Administrator and/or Regional Nurse Consultant will inst the facility's social worker(s) and administration on the requirement resident and/or the resident's responsant has taste ombudsman be of a resident's discharge/transfer.	will s who red fied at overy state  been ted at r ervice nursing that the nsible	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/19/2019 FORM APPROVED

OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 495353 B. WING 03/06/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 900 S MAIN ST HERITAGE HALL BLACKSTONE **BLACKSTONE, VA 23824** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Monitoring: F 623 | Continued From page 39 F 623 The Social Services Director will be If the information in the notice changes prior to responsible for maintaining compliance. The Social worker, and/or Admissions effecting the transfer or discharge, the facility Director will conduct chart audits weekly must update the recipients of the notice as soon of all residents who have been discharged as practicable once the updated information and/or transferred from the facility. becomes available. Any/all negative findings and or errors will be corrected at time of discovery and §483.15(c)(8) Notice in advance of facility closure disciplinary action will be taken as In the case of facility closure, the individual who is needed. Aggregate findings of these the administrator of the facility must provide audits will be reported to the Quality written notification prior to the impending closure Assurance Committee quarterly for to the State Survey Agency, the Office of the review, analysis, and recommendations State Long-Term Care Ombudsman, residents of for change in facility policy, procedure, the facility, and the resident representatives, as and/or practice. well as the plan for the transfer and adequate Completion Date: April 17, 2019 relocation of the residents, as required at § 483.70(I). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review, it was determined that the facility staff failed to evidence written notification of the hospital transfer was provided to the resident and or responsible party for five of 51 residents in the survey sample; Residents #141, #45, #153, #92, #38. 1. The facility staff failed to evidence that Resident #141's responsible party was provided with written notification of the hospital transfer when the resident was transferred to the hospital on 12/23/18. 2. The facility staff failed to provide Resident # 45 or the resident's representative written notification when the resident was transferred to the hospital on 11/25/18.

3. The facility staff failed to evidence that Resident #153's responsible party was provided

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
		495353	B. WING				C 06/2019
	PROVIDER OR SUPPLIER GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STA 900 S MAIN ST BLACKSTONE, VA 2382	,	, 03/	00/2019
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F 623	with written notificate when the resident von 2/15/19.  4. Resident #92 was on 10/3/18. The factor of and/or the resident.  5. The facility staff of notification to the resparty, of a facility in #38 on 11/9/18.  The findings include  1. The facility staff Resident #141's reswith written notificate when the resident von 12/23/18.  Resident #95 was a 1/26/17 with the dianot limited to atrial of with behaviors, bipon and dysphagia. The Data Set) was a sig with an ARD (Asses 1/25/19. The resident von 2/15/19. The resident von 12/15/19.	tion of the hospital transfer was transferred to the hospital as transferred to the hospital cility staff failed to provide of the transfer to Resident #92 is representative.  Tailed to provide written esident and/or responsible itiated transfer for Resident	F6				
	5:30 am CNA notified bleeding; upon asset	d 12/23/18 documented, "At ed this writer of rectal essment: moderate amount ed with clots oozing from				v v rýský Addichálchálchála a roma na mem nem memere v	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495353	B. WING			C 03/06/2019	
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		00/2010	
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F 623	rectum; blood conticleansedorder giacute care"  Further review of the reveal any evidence was notified in writing.  On 3/06/19 at 2:45 #2 (Other Staff Mer Services) she state Discharge/Transfer but that this only state Discharge/Transfer but that this only state documented, "I und discharged/transfer understand the reast (two long lines provided for the transfer)	nued to ooze post area being ven to transfer resident to e clinical record failed to that the responsible partying of the hospital transfer.  p.m., in an interview with OSM inber, Director of Social did that she sends the form to the responsible party, arted in January 2019.  charge/Transfer Form" which is being created January 2019, lerstand that I am being	F6	23			

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
		495353	B. WING		03	C <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE	(X5) COMPLETION DATE
F 623	Staff Member - the aware of the finding provided by the end.  2. The facility staff 45 or the resident's notification when the the hospital on 11/2. Resident # 45 was 07/29/14 and a readiagnoses that incluretention of urine, ubenign prostatic hyll (3) and hypertension. Resident # 45's moset), a 30-day asse (assessment reference Resident # 45 as so interview for mental - 15, 9 (nine) - being cognition for making for Resident # 45 as resident was transferency room for documented, "Atter (responsible party) Transport) squad in Hospitals) were on	p.m., ASM #1 (Administrative Administrator) was made gs. No further information was d of the survey.  failed to provide Resident # representative written e resident was transferred to 25/18.  admitted to the facility on admission on 11/30/18 with uded but were not limited to: urinary tract infection (1), perplasia (2), diabetes mellitus in (4).  st recent MDS (minimum data ssment with an ARD ence date) of 12/19/18, coded coring a 9 (nine) on the brief I status (BIMS) of a score of 0 g moderately impaired of	F6	523		
	stated they had no accept resident with	gency room) nurse, who available beds but would n possible transfer to another t with res en route to (Name of 1:45 p.m.)."	Walter management paragement because of			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495353	B. WING				C <b>06/2019</b>
	PROVIDER OR SUPPLIER	NE		9	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 623	reveal any evidence was notified in writin On 3/06/19 at 2:45 conducted with OSI Director of Social S sends the Discharg responsible party, b January 2019.  A review of the "Dis was documented at documented, "I und discharged/transfer understand the reast (two long lines provided for the transfer) R (long line provided for date); (for this option provided for the write was mailed to the reform was not utilize hospital transfer.	e clinical record failed to e that the responsible partying of the hospital transfer.  p.m., an interview was W #2 (Other Staff Member, ervices). OSM #2 stated shee/Transfer form to the out that this only started in charge/Transfer Form" which is being created January 2019, erstand that I am being red from (facility). I son for discharge/transfer is: ided for writing in the reason responsible Party Signature: for signature); Date: (line Copy Given (a box to check ded); Copy Mailed on: (a line ting in of the date the notice esponsible party)" This diduring the time of the above	F 6	523	DEFICIENCY)		
	(administrative staft administrator and A	roximately 3:30 p.m. ASM member) # 1, the SM # 3, regional nurse ade aware of the findings.	A Park A Marina A Admin A Park				
A CONTRACTOR OF THE CONTRACTOR	No further informati	on was provided prior to exit.					
	information was obt	ne urinary tract. This ained from the website: .gov/medlineplus/ency/article/					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. DOILD	1110	THE RESIDENCE OF THE PROPERTY	,	o	
		495353	B. WING			03/	06/2019	
	PROVIDER OR SUPPLIER  BE HALL BLACKSTOR	NE		٤	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 S MAIN ST BLACKSTONE, VA 23824			
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F 623	Continued From pa	ge 44	Fθ	523				
	obtained from the w	state. This information was rebsite: .gov/medlineplus/enlargedpro						
	regulate the amoun information was obt	e in which the body cannot t of sugar in the blood. This ained from the website: .gov/medlineplus/ency/article/						
	(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.							
	Resident #153's res with written notifical	ailed to evidence that sponsible party was provided ion of the hospital transfer vas transferred to the hospital						
	9/13/16. Diagnoses but are not limited to disturbances, bipola pressure, and asthr Data Set (MDS) wa status assessment Reference Date (AF	admitted to the facility on so for Resident #153 included to dementia with behavioral ar disorder, high blood ma. Resident #153's Minimum is a significant change in with an Assessment RD) of 1/15/19, and coded everely impaired for cognitive ion-making.				:		
	note dated 2/15/19 documented, "1:1 n	nonitoring has continued since t 1140-(Name of Doctor) in						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED		
		495353	B. WING		1	C <b>/06/2019</b>	
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		3012010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 623	appropriate setting other, and order wr hospital) er (Emerg (psychiatric) eval (eadmission re: beha (message) for rp (F call to facility. resideing sent to (Nam town, state) by stree possible admit to he previous behaviors 'okay.' at 1150 spokstaff) at (Name of the transport resident to 1225 2 attendants vambulance) in facili (Name of hospital) given to (name of Eat (Name of hospital) given to (name of Eat (Name of hospital) er for psychospital) er for psychospital) er for psychospital) er for psychospital edmit. rp versidents bed at \$1 'I dont {sic} have the administrative direction was notified in writing the property of the "Diswas documented as adocumented as documented as do	for safety of resident and itten to go to (Name of ency Room) for psych evaluation) for possible viors. This writer left msg desponsible Party) to return lent was oriented that he was e of hospital) er in (Name of tcher for eval (evaluation) and ospital to help with his resident smiled and said to with (Name of transport ambulance) to (Name of hospital) er. at with (Name of transport transport ambulance) to (Name of hospital) er. at with (Name of transport ty and enroute via stretcher to er at 1235. at 1242 report was ER staff) rn (Registered Nurse) al) er."  The clinical record revealed a 2/15/19 at 5:46 p.m., that to returned call to facility esident was sent to (Name of the (psychological) eval with the was asked about holding 95 per day, rp declined stating er money.' (Name of the clinical record failed to e that the responsible party ing of the hospital transfer.  The clinical record failed to e that the responsible party ing of the hospital transfer.  The charge/Transfer Form which is being created January 2019, lerstand that I am being	F 623				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495353	B. WING		03	C 3/06/2019
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP COD 900 S MAIN ST BLACKSTONE, VA 23824		3,00,2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 623	understand the read (two long lines provided for the transfer)F (long line provided provided for date); for this option provip provided for the write was mailed to the reinformation regarding transfer to RP was.  On 3/06/19 at 2:45 #2 (Other Staff Mer Services) she state Discharge/Transfer but if the information the mailing of notify did not mail it."  A review of the facil Discharge, Emerge it become necessal transfer or discharge institution, our facility procedurese. Not (sponsor) or other fidid not specify that writing.  On 3/06/19 at 6:36 Staff Member - the aware of the finding provided by the end	son for discharge/transfer is: ided for writing in the reason desponsible Party Signature: for signature); Date: (line Copy Given (a box to check ded); Copy Mailed on: (a line ting in of the date the notice esponsible party)" The ng the mailing of notification of not completed on the form.  p.m., in an interview with OSM nber, Director of Social d that she sends the form to the responsible party, n is not completed regarding ing the RP of the transfer, I ity policy, "Transfer or ncy" documented, "4. Should by to make an emergency e to a hospital or other related the ty will implement the following tify the representative amily member" The policy notification must occur in PM, ASM #1 (Administrative Administrator) was made is. No further information was	F 6	23		
	10/3/18. The facility	y staff failed to provide written ansfer to Resident #92 and/or				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING				(X3) DATE SURVEY COMPLETED		
<b>495353</b> B. WING		B. WING	WING			C <b>03/06/2019</b>		
	PROVIDER OR SUPPLIER	NE		9	STREET ADDRESS, CITY, STATE, ZIP CODE 100 S MAIN ST BLACKSTONE, VA 23824	1 03/	00/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 623	11/3/11. Resident is were not limited to cholesterol and cormost recent MDS (assessment with a date) of 1/18/19, coognitively intact.  Review of Resident the resident present and was transferred. Further review of Resident to reveal writt was provided to the representative.  On 3/6/19 at 10:28 conducted with LP1 and RN (registered #1 was asked if nut to residents are transistated they call the written notice in a pto the hospital. RN written notice was pwas transferred to the could not provide exprovided to Resider representative whe to the hospital on 1	admitted to the facility on #92's diagnoses included but high blood pressure, high nyulsions. Resident #92's minimum data set), a quarterly n ARD (assessment reference oded the resident as being at #92's clinical record revealed atted with a fever and nausea, do to the hospital on 10/3/18. The included the resident and/or the resident and/or the a.m., an interview was a licensed practical nurse) #4 nurse) #1. LPN #4 and RN reses provide written notification their representatives when ferred to the hospital. RN #1 representative and send a packet when residents are sent at the stated he was not sure if the provided when Resident #92 the hospital on 10/3/18.  The included he was not sure if the provided when Resident #92 the hospital on 10/3/18.  The included he was transferred to the resident was transferred to the resi		523				
	member) #1 (the a	dministrator), ASM #3 (the sultant) and ASM #4 (the						

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		495353	B. WING			C 3/06/2019	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 900 S MAIN ST BLACKSTONE, VA 23824	· · · · · · · · · · · · · · · · · · ·	3/00/2019	
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F 623	No further informa  5. The faciltiy staff notification to the real party, of a facility in #38 on 11/9/18.  Resident #38 was 12/15/16 with a recivith diagnoses that to: urinary tract information in the dementia, kidney so of tissue by bacter infection) (1). The data set) assessment with an assessment coded the resident term memory difficulting. The nurse's note of the nurse's nurse of the nurse of the nurse's nurse of the n	dent of operations) was made e concern.  tion was presented prior to exit.  failed to provide written esident and/or responsible nitiated transfer for Resident  admitted to the facility on cent readmission on 11/21/18, to included but were not limited ection, diabetes, depression, stones, and sepsis (destruction ial toxins, contamination, most recent MDS (minimum ent, a quarterly assessment at reference date of 2/27/19, as having both short and long sulties.  Lated 11/10/18 at 2:02 a.m. t, "Late entry for evening shift ed well in bed, IV (intravenous) ne) infusing in rt (right) th increased coughing episode a few bites. RP (responsible tendants in to pick up resident ital) for evaluation of lethargy ake." Review of the clinical dence the resident and or the ative were provided written 1/10/18 hospital transfer.  p.m., in an interview with OSM mber, Director of Social	F 6	23			
		ed that she sends the r form to the responsible party,					

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

Event ID: 82QJ11

Facility ID: VA0108

If continuation sheet Page 49 of 131

MAR 2 9 2019 VDH/OLC

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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MANE OF BI	ROVIDER OR SUPPLIER	*33333	1 51 11	ST	REET ADDRESS, CITY, STATE, ZIP CODE	83/0	0/2019
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F 623	but that this only star  Administrative staff n administrator, ASM # consultant, and ASM president of operatio above findings on 3/6 p.m.  No further informatio  (1) Barron's Dictiona	nember (ASM) #1, the 13, the regional nurse #4, the regional vice ns, were made aware of the 6/19 at approximately 6:00  In was obtained prior to exit.  Try of Medical Terms for the 1, 5th edition, Rothenberg and	F	623			
F 625 SS=D	Notice of Bed Hold F CFR(s): 483.15(d)(1) §483.15(d) Notice of §483.15(d)(1) Notice of nursing facility transit the resident goes on nursing facility must the resident or residespecifies- (i) The duration of the any, during which the return and resume in facility; (ii) The reserve bed plan, under § 447.40(iii) The nursing facility bed-hold periods, we paragraph (e)(1) of the resident to return; as	Policy Before/Upon Trnsfr (2)  Ded-hold policy and returnation to before transfer. Before a fers a resident to a hospital or therapeutic leave, the provide written information to the representative that  e state bed-hold policy, if the resident is permitted to the esidence in the nursing payment policy in the state of this chapter, if any; lity's policies regarding thich must be consistent with this section, permitting a	F	625	F625 Corrective Action(s): Resident #45 & #92 and their RP's have notified that the facility failed to provious with the facility Bed-Hold policy where transferred to the hospital. Resident #4 and their RP's have had the facility be policy reviewed with them by the admit director. An Incident and Accident repleen completed for each resident ident the review.  Identification of Deficient Practice(s Corrective Action(s): All other residents could potentially be The Bed-Hold policy and forms are not the nursing station for after hour's transfer hospital to be completed by the chanurse. The Social Services director/Addirector will be responsible for normal hour transfer notification of all bed-ho residents and/or Responsible parties.	de them 15 & #92 1-hold issions ort has ified in  and affected. w kept at esfers to arge missions business	

F 625 Continued From page 50 §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REGUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for two of 51 residents in the survey sample, Residents # 45 and # 92.  1. The facility staff failed to provide Resident # 45 or the resident's representative winten notification of the bed hold policy when the resident was transferred to the hospital on 11/25/18.  2. The facility staff failed to provide Resident # 45 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 11/25/18.  Resident # 45 was admitted to the facility on	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 625 Continued From page 50 \$483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:  Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for two of 51 residents in the survey sample, Residents # 45 and # 92.  1. The facility staff failed to provide Resident # 45 or the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 11/25/18.  2. The facility staff failed to provide Resident # 45 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 11/25/18.  Resident # 45 was admitted to the facility on					90	0 S MAIN ST		
Systamatic Change().  Systamatic Change().  Systamatic Change().  The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social services Director, Admissions Director and licensed nursing staff have been inserviced in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by:  Based on resident interview, staff interview, facility document review, and clinical record review, it was determined that facility staff failed to provide a bed hold policy to the resident or the resident's representative upon a transfer to the hospital for two of 51 residents in the survey sample, Residents # 45 and # 92.  1. The facility staff failed to provide Resident # 45 or the resident's representative written notification of the bed hold policy when the resident's representative written notification of the bed hold policy when the resident's representative written notification of the bed hold policy when the resident was transferred to the hospital on 10/3/18.  The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social service due to reviewed and no changes are warranted at this time. The Social service due to reviewed and no changes are warranted at this time. The Social service due to the bed-hold requirement and the proper use and notification of Bed-Hold policy.  Monitoring:  The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social service due to inservice due to ministration on the bed-hold requirement and the proper use and notification of Bed-Hold policy.  Monitoring:  The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service durector and/or Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director and Social Service	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI	3E	COMPLETION
07/29/14 and a re-admission on 11/30/18 with diagnoses that included but were not limited to:	F 625	§483.15(d)(2) Bed-hot the time of transfer o hospitalization or the facility must provide resident representati specifies the duration described in paragra. This REQUIREMENT by: Based on resident in facility document review, it was determ to provide a bed hold resident's representationspital for two of 51 sample, Residents #  1. The facility staff for the resident was transfered in the resident's representation of the bear esident was transfered in the resident's representation of the bear esident was transfered in the findings included.  1. The facility staff for the resident's representation of the bear esident's representation of the bear esident's representation.  The facility staff for the resident's representation of the bear esident was transfered to the hold policity.  Resident # 45 was a 07/29/14 and a re-a	old notice upon transfer. At 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 Interview, staff interview, riew, and clinical record nined that facility staff failed of policy to the resident or the ative upon a transfer to the residents in the survey set 45 and # 92.  ailed to provide Resident # representative written of hold policy when the rred to the hospital on  ailed to provide Resident #92 resentative written notification by when the resident was respital on 10/3/18.  crialled to provide Resident # representative written and hold policy when the red to the hospital on  admitted to the facility on definited to the facility on demission on 11/30/18 with	F	625	The facility Policy and Procedure has be reviewed and no changes are warranted time. The Social Services Director, Ad Director and licensed nursing staff havinserviced by the administrator on the requirement and the proper use and not of Bed-Hold policy.  Monitoring:  The Admissions Director and Social Sed Director are responsible for compliance transfers/discharges from the facility wandited the by the Social service directed Admissions Director to ensure proper be notification was completed at the time or therapeutic leave. Any/all negative f will be corrected at time of discovery. Tresults of these audits will be forwarded Quality Assurance Committee quarterly review, analysis, and recommendations change in facility policy, procedure, an practice.	at this missions be been bed-hold tification  ervice c. All ill be or and/or bed-hold of transfer indings The d to the y for s for	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
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F 625	retention of urine, ubenign prostatic hyl (3) and hypertension recent MDS (minimassessment with ar date) of 12/19/18, coring a 9 (nine) of status (BIMS) of a smoderately impaired decisions.  The nurse's "Progrefor Resident # 45 arresident was transfered emergency room for documented, "Atter (responsible party)	ge 51 rinary tract infection (1), perplasia (2), diabetes mellitus n (4). Resident # 45's most um data set), a 30-day n ARD (assessment reference coded Resident # 45 as n the brief interview for mental score of 0 - 15, 9 (nine) - being d of cognition for making daily ess Notes," dated 11/25/2018 t 11:53 p.m. documented the erred to the hospital or evaluation. The note further npts made to contact RP on all 3 numbers. (Name of n, stated both (Name of two	F6	525		
	Hospitals) were on (emergency medical Hospital) ER (emer stated they had no accept resident with hospital. Squad lef Hospital) at 2345 (1) Review of the EHR the clinical record for the state of the st	diversion. Call placed by EMT al technician) to (Name of gency room) nurse, who available beds but would a possible transfer to another t with res en route to (Name of				
	representative was of the bed hold policy transferred to the hold on 03/06/19 at 2:55 conducted with OSI admissions director hold policy for resid the hospital. OSM	provided a written notification by when the resident was				

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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F 625	review of Resident in 11/25/18, OSM #3 is transfer was before forms and that there bed hold policy was Resident # 45's resident # 7'prior the hospital, the factinformation to the representative regation of 19 at application and Acconsultant, were made administrator and Acconsultant, were made administrator and Acconsultant, were made administration was obton the formation was obton the state of 19 and 19	arge and transfer form." After # 45's transfer form dated stated that Resident # 45's they developed the new e was no evidence that the provided to Resident # 45 or consible party at the time of Bed Hold Prior to Transfer" to transferring a resident to sility will provide written esident and/or the resident and/or the resident anding bed hold."  Toximately 3:30 p.m. ASM member) # 1, the SM # 3, regional nurse ade aware of the findings.  On was provided prior to exit.  This ained from the website:  Legov/medlineplus/ency/article/	F6	525			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 625	obtained from the whttps://www.nlm.nih essure.html.  2. The facility staff for the resident's repof the bed hold polic discharged to the hold scharged on 10/4/18 docume admitted to the hos resident's representative was regarding the facility on 3/5/19 at 11:38 a conducted with Resvoiced concern that return to the same readmitted to the fa 10/12/18. When as facility bed hold policed supposed to the same readmitted to the facility bed hold policed supposed to the hold policed scharge readmitted to the facility bed hold policed supposed to the hold policed supposed	sure. This information was rebsite: .gov/medlineplus/highbloodpr ailed to provide Resident #92 presentative written notification by when the resident was pospital on 10/3/18.  Idmitted to the facility on 192's diagnoses included but high blood pressure, high vulsions. Resident #92's minimum data set), a quarterly ARD (assessment reference ded the resident as being 192's clinical record revealed the with a fever and nausea, and to the hospital on 10/3/18. A by RN (registered nurse) #1 anted Resident #92 was poital for kidney stones and the pative did not wish to have a seriew of Resident #92's to reveal the resident and/or provided written information or bed hold policy.  The resident #92.  The resident she was not permitted to	F 6	25		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/19/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL' A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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F 625	verbal notice of the far Resident #92's reprewas sent to the hosp provide written notice representative. RN # process is to send the resident to the hospit evidence the bed hol Resident #92 (or the was sent to the hospit on 3/6/19 at 4:50 p.r member) #1 (the addregional nurse consuregional vice preside aware of the above of	n., an interview was  1. RN #1 stated he provided acility bed hold policy to sentative when the resident ital. RN #1 stated he did not e of the bed hold policy to the #1 stated the current facility e bed hold policy with the real but he could not provide d policy was provided to representative) when she ital on 10/3/18.  n., ASM (administrative staff ninistrator), ASM #3 (the alltant) and ASM #4 (the nt of operations) was made	F	625			
F 656 SS=E	GFR(s): 483.21(b)(1) §483.21(b) Compreh §483.21(b)(1) The faimplement a comprecare plan for each reresident rights set fo §483.10(c)(3), that in objectives and timefinedical, nursing, anneeds that are identical assessment. The condescribe the following (i) The services that or maintain the residential physical, mental, and	nensive Care Plans cility must develop and hensive person-centered sident, consistent with the rth at §483.10(c)(2) and notudes measurable rames to meet a resident's d mental and psychosocial fied in the comprehensive mprehensive care plan must	F	656	F656 Corrective Action(s): Resident #53's comprehensive care p has been reviewed and revised to refl appropriate goals and interventions a approaches to address the resident's specific medical and treatment needs include her noncompliance with wea her physician ordered oxygen. A Fac Incident & Accident Form was comp for this incident.	ect nd to ring ility	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 656	(ii) Any services that under §483.24, §483. provided due to the nunder §483.10, including features are a result of recommendations. If findings of the PASAI rationale in the reside (iv) In consultation wit resident's representa (A) The resident's representa (A) The resident's profuture discharge. Fact whether the resident's community was asselocal contact agencie entities, for this purportion. This REQUIREMEN' by:  Based on observation document review and was determined the and/or implement the for four of 51 resident Residents #53, #1041. On 3/5/19, Reside separate occasions continuous oxygen in failed to evidence are	would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 3.10(c)(6).  ervices or specialized at the nursing facility will PASARR a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and eference and potential for cilities must document as desire to return to the assed and any referrals to be and/or other appropriate one in accordance with the hin paragraph (c) of this  It is not met as evidenced on, staff interview, facility at clinical record review, it facility staff failed to develop a comprehensive care plan ats in the survey sample,	F	656	Resident #104's comprehensive care has been reviewed and revised to ref appropriate goals and interventions a approaches to address the resident's specific medical and treatment needs include her diagnosis of diabetes and care being delivered for the diabetes Facility Incident & Accident Form was completed for this incident.  Resident #98's comprehensive care has been reviewed and revised to rethe current goals and interventions approaches to address the resident's specific medical and treatment need include the use of a Prevalon Boots in bed, the care and treatment for the sacral wound and the use of bilater mats to the residents bed at all time in bed. A Facility Incident & Accident #138's comprehensive can has been reviewed and revised to reappropriate goals and interventions approaches to address the resident specific medical and treatment need include the care and treatment ne	plan flect and sto while are all fall swhile lent ent.  re plan effect and sto while are all fall swhile lent ent.  re plan effect s and sto ded to ded to ility	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 656	noncompliant with we notification to the phy comprehensive care  2. The facility staff fa comprehensive care #104's diabetes and  3a. On 3/5/19 during Resident #98 was obboots in place per the comprehensive care  3b. The facility staff fa comprehensive care sacral wound and the resident's bed, ir side of the bed per the comprehensive care  4. The facility staff fa #138's a comprehen residents pain and the residents pain and the residents pain.  The findings include  1. On 3/5/19, Reside separate occasions continuous oxygen if ailed to evidence as staff reapplying the sacral wound and the sa	earing her oxygen and visician per the plan.  illed to develop a plan to address Resident the care required.  g separate observations served without prevalon e physician orders and plan.  failed to develop a to address Resident # 98's e care required.  failed to implement Resident e care plan for fall mats per 3/5/19, separate ad Resident #98 in bed with the floor, on the left side of instead of a fall mat to each the physician's order and plan.  failed to develop Resident sive care plan to address the ne care required to address the ne care required to address	F	656	Identification of Deficient Practices & Corrective Action(s): All residents may have potentially be affected. A 100% review of all comprehensive care plans will be conducted by the DON, ADON, RCG and/or designee to identify residents inaccurate or incomplete comprehen care plans. Resident identified with inaccurate or incomplete care plans have their care plan reviewed and up to reflect their current interventions appropriate approaches to address the medical and treatment needs. A Fact Incident & Accident Form will be completed for each incident identification.  Systemic Changes:  The facility Policy and Procedure in been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by 24 Hours Report and documentation the medical record and physician of will be used to develop and revise comprehensive plans of care. The IDT and the DON will be inservice the regional nurse consultant on the development, revision and implementation process of individuance plans.	with sive will odated and neir ility ed.  as y the on in rders RCC, ed by e	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 656	notification to the phycomprehensive care  Resident #53 was ac 2/24/17 with diagnos limited to: hypothyro of the thyroid gland (breakdown of muscle release of muscle fit. These substances a often cause kidney of disc disease [disc di characterized by the one or more of the of the spine (3)], and chronic, nonreversible a combination of embronchitis (4)].  The most recent ME assessment, a quarrassessment, a quarrassessment referent he resident as scor interview for mental was moderately implecisions. The resident upon on all of her activities of Special Treatments the resident was coresident in the facility. Resident #53 was ca.m., the resident was mater. The oxygen The oxygen tubing the end of the tubing the control of the tubing the end of tubing the end of the tubing the end of the tubing the end of the tubing the end of tubing the end of tubing the end of tubing the	dimitted to the facility on the sthat included but were not ad disease [decreased activity (1)]; rhabdomyolysis [is the set issue that leads to the set contents into the blood. The harmful to the kidney and damage (2)], degenerative sease is a common condition breakdown (degeneration) of iscs that separate the bones of COPD [general term for the lung disease that is usually aphysema and chronic of the lung disease that is usually aphysema and chronic of the lung disease that is usually aphysema and chronic of the lung disease that is usually aphysema and chronic of the lung disease that is usually aphysema and chronic of date of 12/21/18, coded ing a "8" on the BIMS (brief status) score, indicating she paired to make cognitive daily lent was coded as completely the or more staff members for a fadily living. In Section O and Programs of the procedures and Programs of the procedures and Programs of the procedures of 3/5/19 at 9:05 areas in her bed, drinking some tubing was not on the resident. Was observed hanging over g closest to the concentrator, touching the ground. The	F	656	Monitoring: The RCC and DON are responsible maintaining compliance. The DON are responsible maintaining compliance. The DON are coinciding with the care plan audits we coinciding with the care plan calend monitor for compliance. Any/all neg findings will be reported to the DON RCC for immediate correction. Detaindings of the interdisciplinary tear audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure and/or practice.  Completion Date: April 17, 2019	and/or veekly ar to gative N / ailed m's	

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

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F 656	A second observation 3/5/19 at 12:33 pasleep. The oxyger and the tubing remark closet to the concernsident.  The third observation at 3:42 p.m. reveals oxygen via a nasal prongs that insert in oxygen concentrate.  The physician order "O2 (oxygen) at 2L/continuous."  The comprehensive 12/21/18, document Resident is non-cor O2 off." The "Appro" "Encourage O2 use about being non-co Document and report RP (responsible parwhen noticed off."  Review of the nurse evidence document the resident's oxygen	ge 58 on was made of Resident #53 o.m. The resident was in bed o concentrator was running ained hanging off the tubing ntrator, and was not on the on of Resident #53 on 3/5/19 ed the resident receiving her cannula (a tubing with two nto the nose) connected do an	F 656	DEFICIENCY)		
	An interview was conurse) #3, the unit rp.m. RN #1 was as for oxygen and to de	inysician of non-compliance. Inducted with RN (registered manager, on 3/6/19 at 3:15 ked if a resident has an order ocument noncompliance and dithe residents oxygen was				

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

Event ID: 82QJ11

Facility ID: VA0108

If continuation sheet Page 59 of 131

MAR 2 9 2019 VDH/OLC

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	TIPLE CONSTRUCTION  ING			E SURVEY PLETED
		495353	B. WING				) 0 <b>6/2019</b>
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F 656	comprehensive car nothing, regarding noncompliance with physician notification be following the car.  An interview was controlled in the resider per the physician of documents to admit physician order, we plan, LPN #9 states.  The facility policy, "Person-Centered" of Interdisciplinary Teather resident and his	sident, is the staff following the e plan if staff documented reapplying the oxygen, or wearing the oxygen, or on. RN #3 stated it would not be plan.  In the plan of the plan	F 6				
	comprehensive, pe each resident."  Administrative staff administrator, ASM consultant, and ASI president of operati above findings on 3 p.m.  No further information (1) Barron's Diction	member (ASM) #1, the #3, the regional nurse M #4, the regional vice ons, were made aware of the M6/19 at approximately 6:00 on was provided prior to exit. ary of Medical Terms for the er, 5th edition, Rothenberg and					
	following website: https://medlineplus.	was obtained from the gov/ency/article/000473.htm was obtained from the				<u> тейненден ден ден ден ден ден ден ден ден д</u>	

	F CORRECTION	IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		E SURVEY IPLETED
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F 656	following website: https://ghr.nlm.nih.gc-disease. (4) Barron's Diction Non-Medical Reade Chapman, page 12	nov/condition/intervertebral-dis ary of Medical Terms for the er, 5th edition, Rothenberg and 4.	F6	56			
	#104's diabetes and Resident #104 was 1/5/19 with diagnos limited to: diabetes, requiring hemodialy conditions and rena wastes and impuriti- blood by a special n	e plan to address Resident If the care required.  admitted to the facility on es that included but were not chronic kidney disease sis [a procedure used in toxic I [kidney] failure, in which es are removed from the nachine (1)], history of Ift leg and toes on his right					
	assessment, a Med with an assessment coded the resident a (brief interview for nother resident was calcognitive decisions. requiring from limited activities of daily living the second	DS (minimum data set) icare 30 day assessment, reference date of 2/2/19, as scoring a "15" on the BIMS nental status) score, indicating pable of making daily The resident was coded as d to total assistance for his ng. In Section I - Health dent was coded as having					
	reviewed. The care	care plan dated 1/13/19 was plan failed to address the and care required including ulin.					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION	COM	E SURVEY MPLETED
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F 656	The physician order in part, "Lantus Sold long acting insulin tunits SQ (subcutan An interview was copractical nurse) #1 asked if a resident I addressed on their believe so." LPN #1 Resident #104's car #1 was asked if the diabetes was in the #1 stated, "I don't so An interview was conurse) #3, the unit ra.m. When asked if should have a care RN #3 stated, "Yes, asked to review Resident to review RN #3 sooked in the clinical diabetes addressed she said it didn't get comprehensive care should have been comprehensive care Administrative staff administrator, ASM consultant, and ASN president of operaticabove findings on 3 p.m.	rs dated 1/11/19 documented obstar 100unit/ML (milliliters) (a used to treat diabetes) (2) 5 eously) daily for diabetes."  Inducted with LPN (licensed on 3/6/19 at 11:55 a.m. When has diabetes, should that be care plan, LPN #1 stated, "I was asked to review re plan. After the review, LPN resident's diagnosis of resident's plan of care, LPN ee it."  Inducted with RN (registered manager, on 3/6/19 at 11:57 a resident with diabetes plan to address the diabetes, it should be." RN #3 was sident #104's care plan. After tated, "It's not there." RN #3 I record and found the to carried over to the eplan. When asked if it	F6	56			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED
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F 656	Chapman, page 26 (2) This information following website: https://medlineplus.tml  3a. On 3/5/19 durir Resident #98 was a boots in place per the comprehensive care. Resident #98 was a 12/17/2018. Diagnobut were not limited Pressure, and Depressure, and Depressure, and Depressure, and Depressure, and Depressure, and Depressure impairment Data Set coded Resident with an Assessmen 01/18/2019 coded Frognitive impairment Data Set coded Resident with an Assessmen O1/18/2019 and total feeding).  On 03/05/2019 at a Resident #98 was oright side, under a lifet exposed. Resident #98 was oright side, under a lifet exposed. Resident #98 was oback, under a light gexposed. Resident both feet were observed.	er, 5th edition, Rothenberg and 6.  was obtained from the gov/druginfo/meds/a600027.h  ag separate observations observed without prevalon ne physician orders and e plan.  admitted to the facility on ses for Resident #98 included to Heart Failure, High Blood ession. Resident #98's (significant change in status) t Reference Date of Resident #98 with severe at. In addition, the Minimum sident #98 as requiring total taff member with activities of dependence for eating (tube  oproximately at 8:40 a.m., abserved lying in bed, on her ght green colored blanket with lent #98 had on gray socks oropped up on a pillow.  oproximately 1:59 p.m., bserved lying in bed, on her green colored blanket with feet #98 had on gray socks and arved propped up on a pillow.	F6			
		sident #98's care plan was #98's care plan and physician				

F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '			E SURVEY MPLETED
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(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI) TAG	( (EACH CORRECTIVE ACTION SHOU	D BE	(X5) COMPLETION DATE
order documented, lower extremities at Resident #98 did no when observed at a 1:59 p.m.  On 03/05/2019 at a Resident 98 was obback, under a light covered. Resident #5 (Licensed Practical remove Resident #5 feet. Resident #98 If feet were observed Resident #98 was LPN #4 asked Resiprevalon boots?" ReLPN #4 then placed #98's feet, which we television.  An interview was coapproximately 10:20 Nurse) (Unit Manag the purpose of the restated that the care nursing staff know was asked who is rethe care plan. RN #1 was asked who is rethe care plan. RN #1 was lan interventions a RN #1 stated that responsible for developing the care plan. RN #1 was lan interventions a RN #1 stated that responsible for developing the care plan. RN #1 was lan interventions a RN #1 stated that responsible for developing the care plan. RN #1 was land interventions a RN #1 stated that responsible for developing the care plan. RN #1 was land interventions a RN #1 stated that responsible for developing the care plan RN #1 was land interventions a RN #1 stated that responsible for developing the care plan RN #1 was land interventions a RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 was land interventions a RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated that responsible for developing the care plan RN #1 stated	"Prevalon boots to bilateral all times" dated 01/18/2019. It have prevalon boots on approximately 8:40 a.m. and at approximately 8:40 a.m. and at approximately 8:40 a.m. and at approximately 8:51 p.m., oserved lying in bed, on her green colored blanket with feet #98's feet were covered. LPN Nurse) #4 was asked to 98's blanket to reveal both and on gray socks and both propped up on a pillow. In the waring prevalon boots, dent #98, "Where are your esident #98 did not respond. If prevalon boots on Resident ere located behind the serior of the serior of the what the resident needs are, who is responsible for a plan. RN #1 stated that the esponsible for implementing 1 stated that the MDS on sible for implementing the as asked staff ensure care re in place and implemented. Sounds are made to ensure that	F 6	56		
	Continued From particles of Action of Continued From particles of Continued From parti	PROVIDER OR SUPPLIER  SE HALL BLACKSTONE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 63 order documented, "Prevalon boots to bilateral lower extremities at all times" dated 01/18/2019. Resident #98 did not have prevalon boots on when observed at approximately 8:40 a.m. and at 1:59 p.m.  On 03/05/2019 at approximately 3:51 p.m., Resident 98 was observed lying in bed, on her back, under a light green colored blanket with feet covered. Resident #98's feet were covered. LPN (Licensed Practical Nurse) #4 was asked to remove Resident #98's blanket to reveal both feet. Resident #98 had on gray socks and both feet were observed propped up on a pillow. Resident # 98 was not wearing prevalon boots. LPN #4 asked Resident # 98 did not respond. LPN #4 then placed prevalon boots on Resident #98's feet, which were located behind the	PROVIDER OR SUPPLIER  SE HALL BLACKSTONE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 63 order documented, "Prevalon boots to bilateral lower extremities at all times" dated 01/18/2019. Resident #98 did not have prevalon boots on when observed at approximately 8:40 a.m. and at 1:59 p.m.  On 03/05/2019 at approximately 3:51 p.m., Resident 98 was observed lying in bed, on her back, under a light green colored blanket with feet covered. Resident #98's blanket to reveal both feet. Resident #98's blanket to reveal both feet were observed propped up on a pillow. Resident #98 was not wearing prevalon boots. LPN #4 asked Resident #98, "Where are your prevalon boots?" Resident #98 did not respond. LPN #4 then placed prevalon boots on Resident #98's feet, which were located behind the television.  An interview was conducted on 03/06/2019 at approximately 10:23 a.m. with RN #1 (Registered Nurse) (Unit Manager). RN #1 was asked what the purpose of the resident's care plan is. RN #1 stated that the care plan is what's used to let nursing staff know what the resident needs are. RN #1 was asked who is responsible for developing the care plan. RN #1 stated that the MDS (Minimal Data Set) Coordinator is responsible for developing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 stated that rounds are made to ensure that care planned interventions are in place. RN #1	PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECOED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 63 order documented, "Prevalon boots to bilateral lower extremities at all times" dated 01/18/2019. Resident #98 did not have prevalon boots on when observed at approximately 8:40 a.m. and at 1.59 p.m.  Con 03/05/2019 at approximately 8:51 p.m., Resident 98 was observed lying in bed, on her back, under a light green colored blanket with feet covered. LPN (Licensed Practical Nurse) #4 was asked to remove Resident #98's blanket to reveal both feet. Resident #98's blanket to reveal both feet. Resident #98 was not wearing prevalon boots. LPN #4 asked Resident #98 did not respond. LPN #4 then placed prevalon boots on Resident #98's feet, which were located behind the television.  An interview was conducted on 03/06/2019 at approximately 10:23 a.m. with RN #1 (Registered Nurse) (Unit Manager). RN #1 was asked what the care plan is what's used to let nursing staff know what the resident needs are. RN #1 was asked what is responsible for developing the care plan. RN #1 stated that the MDS (Coordinator is responsible for implementing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 stated that the MDS Coordinator is responsible for implementing the care plan. RN #1 stated that tho MDS Coordinator is responsible for implementing the care plan. RN #1 stated that thounds are made to ensure that care plan interventions are in place. RN #1	### A BUILDING ### A

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F 656	prevalon boots as of #1 stated that he m wearing her prevalor orders.  An interview was composed approximately 2:42 Practical Nurse) (Masked who is responsible the care plans." LPI of the care plans." LPI of the care plan is to of resident's plan of On 03/06/2019 at an (Administrative Staff ASM #3 (Regional I #4 (Regional Vice Prade aware of finding 3b. The facility staff comprehensive care sacral wound and the Resident #98's Mini Assessment Reference coded Resident #98 M0100 A., "Resident a scar over bony pronon-removable dress Conditions M0150 Fulcers/Injuries coded developing pressure Skin Conditions M05 having 1 unstageab	producted and care planned. RN ade sure the resident was on boots after looking at her conducted on 03/06/2019 at p.m. with LPN #2 (Licensed DS Coordinator). LPN #2 was nsible for developing and care plan. LPN #2 stated, a for developing and updating N #2 was asked the purpose N #2 stated that the purpose N #3 mercial t	F 6	,		
matter paraceters.	that was present up	on admission.				

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION ING	CON	TE SURVEY MPLETED
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F 656	was reviewed. A ph documented, "Clear wound cleanser, parevery day and as not have a comprehens sacral wound and the An interview was comprehens a comprehens sacral wound and the An interview was comproximately 2:42 Practical Nurse) (M (MDS Coordinator) for developing and LPN #2 stated, "MD developing and upon (MDS Coordinator) purpose of the care Coordinator) stated plan is to keep nursiplan of care. LPN # made aware of Rescare plan to address and the care required reviewed Resident at there was not a comprehensive care did have a sacral where the comprehensive care did have a sacral where was not a compreh	sident #98's clinical record ysician order dated 02/04/19 nse sacrum with dermal t dry, apply foam dressing eeded." Resident #98 did not sive care plan addressing her ne care required.  Inducted on 03/06/2019 at p.m. with LPN #2 (Licensed DS Coordinator). LPN #2 was asked who is responsible updating resident's care plan. IS is responsible for ating the care plans." LPN #2 was asked what is the plan. LPN #2 (MDS that the purpose of the care ing staff informed of resident's 2 (MDS Coordinator) was ident #98 not having a wound as the resident's sacral wound ed. LPN #2 (MDS Coordinator) #98's care plan and validated a wound care plan in the eplan and that Resident #98 ound.  Popproximately 12:30 p.m., ASM of Member) #1 (Administrator), Nurse Consultant), and ASM dresident of Operations) were	F 6	556		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
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F 656	reduces blood supp supply can cause the become damaged of obtained from the weather that the https://medlineplus. 00147.htm  3c. The facility staff #98's comprehensing physician order. On observations reveal only one fall mat on the resident's bed, it side of the bed per comprehensive care.  On 03/05/2019 at a Resident #98 was oright side, under a life feet exposed. One fall resident #98's bed  On 03/05/2019 at a Resident #98 was oright side, under a light gexposed. One fall resident #98's bed  On 03/05/2019, Resident #98's bed	oly to that area. Lack of blood he skin tissue in this area to or die. This information was website: gov/ency.patientinstructions/0  failed to implement Resident we care plan for fall mats per 3/5/19, separate led Resident #98 in bed with the floor, on the left side of instead of a fall mat to each the physician's order and e plan.  pproximately at 8:40 a.m., observed lying in bed, on her ight green colored blanket with fall mat was on the left side on the floor.  pproximately 1:59 p.m., observed lying in bed, on her green colored blanket with feet mat was on the left side	F 6			
	approximately 10:23	onducted on 03/06/2019 at 3 a.m. with RN #1 (Registered er). RN #1 was asked what				

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F 656	the purpose of the stated that the care nursing staff know RN #1 was asked developing the car MDS (Minimal Dat responsible for developing the care MDS (Minimal Dat responsible for developing the care plan. RN #1 Coordinator is responsible for developing the care plan. RN #1 vare plan intervent place. RN #1 state ensure that care plan was made a having a fall mat of stated that he corresponded to the orders and care (Administrative States ASM #3 (Regional Vice made aware of find 4. The facility staff #138's a comprehensidents pain and the residents pain.  Resident #138 was 9/14/16. Resident were not limited to B12 deficiency and most recent MDS (significant change ARD (assessment coded the resident impaired. Section	resident's care plan is. RN #1 e plan is what's used to let what the resident needs are. who is responsible for e plan. RN #1 stated that the a Set) Coordinator is veloping the care plan. RN #1 responsible for implementing #1 stated that the MDS consible for implementing the vas asked how staff ensure ions are implemented and in d that rounds are made to lan interventions are in place. aware of Resident #98 not n both sides of the bed. RN #1 ected the issue after reviewing e plan.  approximately 12:30 p.m., ASM aff Member) #1 (Administrator), Nurse Consultant), and ASM President of Operations) were dings. failed to develop Resident ensive care plan to address the the care required to address		556		

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i	TIPLE CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
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F 656	medication and nor during the last five of Resident #138 reported pain as a triggered pain as being address Tylenol (1) 650 mg PRN for pain or a few of Resident #138's (medication administresident was administresident was administresident was administresident #138's conducted with LPN (the nurse who adm Resident #138 on a 2/10/19). LPN #5 conducted with LPN (the nurse who adm Resident #138 on a 2/10/19). LPN #5 conducted with Resident a resident who is reshould have a pain "Yes."  On 3/6/19 at 4:13 p conducted with RN nurse responsible for #2 was made award #2 confirmed Resid care plan and stated date.	ge 68 n-medication intervention days. Section J further coded orted having frequent pain days. Section V documented care area and documented essed in the care plan.  #138's clinical record n's order dated 1/29/19 for (milligrams) every six hours ever greater than 101. Review February 2019 MAR estration record) revealed the istered PRN Tylenol on 19, 2/10/19, 2/11/19, 2/12/19, d 2/18/19. Review of imprehensive care plan dated real documentation regarding  a.m., an interview was I (licensed practical nurse) #5 ninistered PRN Tylenol to II of the above dates except onfirmed she administered #138 for pain. When asked if deiving pain medication care plan, LPN #5 stated,  .m., an interview was (registered nurse) #2 (the or developing care plans). RN ent #2 should have had a pain d she created one on this  .m., ASM (administrative staff .m., ASM (administrative staff	F 6	56		

	OF CORRECTION	(X1) PROVIDEN/SUPPLIEN/CLIA IDENTIFICATION NUMBER:	` '	NG		E SURVEY IPLETED
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F 656	member) #1 (the acregional nurse consequence of the above aware plan for each interventions are deanalysis of the inforcomprehensive assumed aware plan for each interventions are deanalysis of the inforcomprehensive assumed aware plan for each interventions are deanalysis of the inforcomprehensive assumed aware plan for each interventions are deanalysis of the inforcomprehensive assumed aware plan for each interventions are deanalysis of the inforcomprehensive assumed aware of the MDS decomprehensive assumed aware of the MDS decomprehensive assumed aware of the MDS decomprehensive assumed and indicate the new based on problem in "triggered care area between the MDS aplanning. There are 20 CAAs	dministrator), ASM #3 (the sultant) and ASM #4 (the sultant) was made concern.  Iled, "Care Plans, rson-Centered" documented, A comprehensive, Ir plan that includes was and timetables to meet the psychosocial and functional and implemented for each erpretation and The Interdisciplinary Team in with the resident and his/her esentative, develops and orehensive, person-centered resident. 2. The care plan erived from a thorough mation gathered as part of the ressment"  for Medicare and Medicaid ident Assessment Instrument) d: E AREA ASSESSMENT (CAA)	F 6:	56		

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		COMPL	(X3) DATE SURVEY COMPLETED	
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F 657 SS≃D	the majority of care a problematic for nursi Area Assessment (C guidance on how to a during a comprehens directs facility staff at evaluate triggered care interdisciplinary relevant assessment resident's status. After resident, the resident guardian, or legally a IDT decides whether plan for triggered care.  No further information was obtainformation was obtainfor	sferral." These CAAs cover areas known to be any home residents. The Care AA) process provides focus on key issues identified sive MDS assessment and and health professionals to are areas. Iteam (IDT) then identifies a information regarding the er obtaining input from the t's family, significant other, authorized representative, the er or not to develop a care areas."  In was presented prior to exit.  In a prelieve pain. This sained from the website: gov/druginfo/meds/a681004.h  and Revision  In a Revision of assessment.  In terdisciplinary team, that mitted to—	F	557	F657 Corrective Action(s): Resident #145's comprehensive contains been reviewed and revised to specific interventions and approact Nebulizer treatment use for shorten breath per physician order. A Risk Management Incident & Accident was completed for this incident.	reflect hes for ess of	
*	resident.	od and nutrition services staff.					

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

Event ID: 82QJ11

Facility ID: VA0108

If continuation sheet Page 71 of 131

MAR 2 9 2019 VDH/OLC

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F 657	the resident and the An explanation must medical record if the and their resident reprotection practicable for the resident's care plan. (F) Other appropriate disciplines as determ or as requested by the (iii) Reviewed and reviteam after each assessments. This REQUIREMEN' by:  Based on observation record review, it was staff failed to review comprehensive care the survey sample, F.  The facility staff failed care plan to address physician ordered not needed for shortness.  The findings include Resident #145 was a 02/17/2017. Diagnos included but were not pressure, Depression Resident #145's Anri (annual assessment Reference Date of 0 #145 with moderate addition, the Minimus and their resident with their resident	cticable, the participation of resident's representative(s). be included in a resident's participation of the resident presentative is determined as development of the resident's needs are resident. The resident's needs are resident. The resident is not met as evidenced on, staff interview, and clinical determined that the facility and revise the plan for 1 of 51 residents in Resident 145.  In the resident #145's and include the 2/11/19 ebulizer treatments as so for the resident.	F	657	Identification of Deficient Practice & Corrective Action(s):  Any/all residents may have potential been affected. A 100% review of all resident comprehensive care plans we conducted by the RCC and/or design identify residents at risk. Residents identified at risk as having an inacct comprehensive care plan will be contact time of discovery and a Risk Management Incident & Accident F will be completed for each incident identified.  Systemic Changes:  The assessment process will continue to utilized as the primary tool for developing comprehensive plans of The RCC is responsible for implement the RAI Process. The nursing assess process as evidenced by the 24 Hou Report and documentation in the mace record/physician orders will be used develop and revise comprehensive of care. The Regional Nurse Consumil provide in-service training to the interdisciplinary care plan team on mandate to develop individualized plans within 7 days of the completithe comprehensive assessment and revisions to the comprehensive care as indicated with any changes in condition.	lly vill be nee to nrate rected form  ne to care. enting sment urs edical i to plans ltant he the care on of for	

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F 657	limited assistance of On 03/06/2019, Resi was reviewed. A phy 02/11/2019 documen Bromide/Albuterol St (milligrams)/3 ml (mill treatment every four shortness of breath."  Resident #145's Feb administration record of "Ipratropium Brom (2.5) mg (milligrams) nebulizer treatment of for shortness of brea Resident #145's com 02/12/2019 was revia a revision to include and intervention.  On 03/05/2019 at ap Resident #145's neb on top of the dresser  An interview was co approximately 4:15   Nurse) #2 (MDS Co if the physician orde should be care plant should be care plant Resident #145's car and she did not carr	tivities of daily living and one staff person for eating.  dent #145's clinical record sician order dated ted, "Ipratropium ulfate 0.5-3 (2.5) mg liliters) (1) give nebulizer hours as needed for ruary 2019 medication documented administration ide/Albuterol Sulfate 0.5-3	F	657	Monitoring:  The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care calendar to monitor for compliance. Any/all negative findings will be rept to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in faci policy, procedure, and/or practice.  Completion Date: April 17, 2019	plan ported e		

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F 657	A copy of the facility planning was reque (Administrative Staf on 03/06/2019 at application facility policy titled, or Person-Centered", or residents are ongoing as information about residents' condition. Team must review at a. When there has the resident's condition. When the desirt c. When the resident facility from a had. At least quarterly the facility from a had. At least quarterly wassessment."  On 03/06/2019 at application (Administrative Staf ASM #3 (Regional Neglional Neglional Vice Personal Vice	rod it was an as needed order.  r policy regarding care sted from ASM if Member) #1 (Administrator) proximately 4:50 p.m. The Care Plans, Comprehensive documented "Assessments of ing and care plans are revised it the residents and the change. The Interdisciplinary and update the care plan:  s been a significant change in tion; ed outcome is not met; ent has been readmitted to ospital stay; and ly, in conjunction with the linimal Data Set (MDS)  pproximately 6:00 p.m., ASM if Member) #1 (Administrator), Nurse Consultant), and ASM iresident of Operations) were	F 6	557		
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F 658 F 658 SS=D	Services Provided M CFR(s): 483.21(b)(3) §483.21(b)(3) Comp The services provide as outlined by the comust- (i) Meet professiona This REQUIREMEN by: Based on staff inter and clinical record of facility staff failed to of practice for two of sample, Residents #  1. The facility staff fa #145's physician order for of parameters for titrat The findings include  1. The facility staff fa #145's physician order for of parameters for titrat The findings include  1. The facility staff fa #145's physician order for of parameters for titrat The findings include  1. The facility staff fa #145's physician order for of parameters for titrat the findings include  1. The facility staff fa #145's physician order for of parameters for titrat the findings include the findings included the facility staff fa #145's physician order for other facility staff fa #145's physician order facility staff fa #145's phys	leet Professional Standards (ii)  rehensive Care Plans ad or arranged by the facility, comprehensive care plan,  I standards of quality.  T is not met as evidenced  view, facility document review eview, it was determined the follow professional standards f 51 residents in the survey f145 and #25.  ailed to clarify Resident der for oxygen regarding the for titration of the oxygen.  to clarify Resident #25's oxygen regarding the flow rate ion of the oxygen.  c:  ailed to clarify Resident der for oxygen regarding the for titration of the oxygen.  admitted to the facility on es that included but were not a of breath, diabetes, stitial lung disease [Interstitial mame for a large group of the or scar the lungs. The carring make it hard to get	F6	Corrective Action(s): Resident #145 & #25¹ physician has been not facility staff failed to at the correct flow rate ordered titrated oxyge Resident #145 & #25 have been reviewed attending physician a comprehensive care pupdated to reflect the orders. A Facility Inc. Form was completed  Identification of De Practices/Corrective All other residents we may have been poter DON or Unit Manag 100% review of all roxygen orders to iderisk. All residents ideorrected at time of attending physician	's attending stified that the administer oxygen e per the physician en flow rate. 's Oxygen orders and clarified by the not their plans have been current oxygen cident & Accident for these incidents.  ficient e Action(s): with Oxygen orders attally affected. The ger will conduct a resident's with entify any residents at lentified at risk will be discovery and the will be notified of lent & Accident form		

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assessment coadmitted on the The "Nursing A 3/6/19, docume and confused. being depended daily living. The oxygen use on The nurse's not documented ir the percentage 96% on 2 L/M cannula - a tutte the nose).  The physician "O2 continuou May Titrate to The MAR (me March 2019 de L/M via nasal sat 92%."  The "Baseline p.m. document Treatments/Pr Route: N/C (n. minute): 2. From An interview we practical nurse order above for When asked it.	MDS ( impletion of the result	minimum data set) ed as the resident was day of survey.  ion Assessment" dated the resident as being alert esident was documented as on the staff for his activities of as no documentation of orm.  ed 3/4/19 at 11:08 p.m.  "O2 (oxygen) sat (saturation exygen in the blood stream) per minute) via NC (nasal etwo prongs that inserts into  dated 3/5/19, documented, ett) 2 L/M via nasal cannula. ain O2 sat 92%."  In administration record) for inted, "O2 continuous @ 2 ia. May titrate to maintain O2	·	658	Systemic Change(s):  The facility policy and procedure habeen reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by 24 Hours Report, documentation in medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcrib and administering physician ordered medications per physician order. Listaff will be inserviced by the DON and/or regional nurse consultant on policy & procedure for medication administration to include clarifying verifying resident specific oxygen or prior to administration and monitor.  Monitoring:  The DON is responsible for maintar compliance. The DON and/or Unit Manager will review oxygen orders weekly in order to maintain compliancy/all negative findings will be corrected at time of discovery and disciplinary action taken as needed Aggregate findings of these audits reported to the Quality Assurance Committee quarterly for review, an and recommendations for change in facility policy, procedure, and/or procedure, and/or procedure approach is a procedure, and/or procedure approach in the policy, procedure, and/or procedure approach is a procedure approach in the procedure approach is a procedure and/or procedure, and/or procedure approach is a procedure and procedure approach is a proce	the the second the censed the and orders ing.  ining sance.  will be nalysis, or ractice.		

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F 658	When asked how a in oxygen and dowr rate, LPN #1 stated wound not know. I'd doctor would have t up." LPN #1 stated clarification."  An interview was conurse) #3, the unit r a.m., RN #3 was as for oxygen. When a RN #3 stated, "It do go up to." When as order for 'titrate,' RN get clarification bechow high to go and asked if the order dbring the oxygen flowould have to get the doctor."  The facility policy, "I Orders" documente medications must ir of the drug. b. Quar therapy. c. Dosage administration. d. ro Reason or problem  According to Lipping Nursing, 5th edition following statement	isk to see where the sat is." Ind when does the nurse go up in the setting of the liter flow in the set to call the doctor. The in say how high you can go in the set to review the order above is sked to review the order above is sked how to read the order, we not say how many liters to keed about the meaning of the in the set in	F 6	58					
	seems in appropriate  Administrative staff	te." member (ASM) #1. the							

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F 658	consultant, and ASI president of operati above findings on 3 p.m.  On 3/6/19 at 8:15 p nursing, was asked of practice the facili follow their policies  No further information following website:	#3, the regional nurse M #4, the regional vice fons, were made aware of the 1/6/19 at approximately 6:00 cm. ASM #2, the director of which professional standard ty follows, ASM #2 stated they	F	658				
	physician order for parameters for titral Resident #25 was a 12/13/17 with the di Chronic Obstructive respiratory failure was transient cerebral is pressure, and depressure, and depressure, and depressure with an (ARD) of 12/9/18, a moderately cognitive daily life decisions. requiring extensive transfers; total care	to clarify Resident #25's oxygen regarding the flow rate tion of the oxygen.  admitted to the facility on agnoses of but not limited to a Pulmonary Disease, acute with hypoxia, diabetes type 2, achemic attack, high blood ession. Resident #25's (MDS) was an annual an Assessment Reference Date and coded Resident #25 as ely impaired in ability to make The resident was coded as care for toilet use, eating, and for hygiene, bathing, and entinent of bowel and bladder.						

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F 658	A review of the clinic physician's order da "O2 (oxygen) at 2L/NC (nasal cannula) (shortness of breath > 92 (oxygen satura Further clinical recomphysician's orders of documented, "SOB SOB. May titrate to Check O2 sat Qshift An interview was comply a saturated order as written and O2 sat > 92." When follow the order, LP standing order for othe standing order for othe standing order for othe standing orders how low the nurse of LPN #1 stated, "Not liters (per minute). per minute) you can and see where sat (According to this, you call the doctor. The high you can go up, would need clarificated An interview was comply asked how she would stated, "It does not stated, "It does not stated."	cal record revealed a ated 2/28/18 that documented, MIN (2 liters per minute) via PRN (as needed) for SOB n), may titrate to maintain sats ations greater than 92 %)." and review revealed a standing lated 7/19/18 that: O2 at 2L/M via NC prn for maintain O2 sat > 92%. It (every shift)."  Inducted on 3/6/19 at 11:29 regarding Resident #25's O2. When asked how she er, LPN #1 stated back the if "you may titrate it up to make in asked how the nurse would in asked how high or ean go with the oxygen rate, rmally you would not go over 4 lif (the resident is) on 2 (liters in go up to 3 (liters per minute) (oxygen saturation) is. Ou would not know. I'd have to doctor would have to say how "LPN #1 stated, "That order tion."  Inducted on 3/5/19 at 11:36 retered nurse) #3 regarding sician order for oxygen. When ald read the order, RN #3 say how many liters to go up	F 6	558		
TO DO TO THE PROPERTY OF THE P	to. The titrate part,					

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F 658	order) Does not say I down." RN #3 stated, order clarified by the A review of the facility Administration" document orders or facility protest administration."  A review of the facility protest administration."  A review of the facility Medications" document dosage is believed to residentthe person the medication shall Attending Physician Director to discuss the Administration of the findings provided by the end Treatment/Svcs to PCFR(s): 483.25(b)(1) Pressi Based on the compressident, the facility of the finding provided by the end Treatment/Svcs to PCFR(s): 483.25(b)(1) Pressi Based on the compressident, the facility of the finding provided by the facility of the facility	t what increments. (The now or when to bring it "I would have to get this doctor."  y policy, "Oxygen mented the following: y that there is a physician's are. Review the physician's cool for oxygen  y policy, "Administering ented the following: "5. If a be inappropriatefor the preparing or administering contact the resident's for the facility's Medical fie concern."  m., AMS #1 (Administrative diministrator) was made as No further information was of the survey.  revent/Heal Pressure Ulcer (i)(i)(ii)  grity  ure ulcers.  ehensive assessment of a must ensure that- as care, consistent with dos of practice, to prevent does not develop pressure lividual's clinical condition ney were unavoidable; and		658	F686 Corrective Action(s): Resident #53's attending physician notified that the facility staff failed assess, measure, monitor and track sacral wound for resident #53. A fa Incident & Accident form was confor this incident.  Resident #98's attending physician notified that the facility staff failed apply physician ordered prevalon ordered. A facility Incident & Accident &	to a acility apleted a was l to boots as cident		
	1 ' '	ressure ulcers receives t and services, consistent		•	form was completed for this incid	ent.		

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F 686	with professional star promote healing, pre new ulcers from deverance and the facility staff farmonitor and track Resident #98 was of physician ordered Pressure on Resident Resident #53 was a 2/24/17 with diagnolimited to: hypothyroof the thyroid gland) breakdown of musc release of muscle fit These substances a form deverance and track Resident #53 was a 2/24/17 with diagnolimited to: hypothyroof the thyroid gland) breakdown of musc release of muscle fit These substances as	ndards of practice, to vent infection and prevent eloping.  T is not met as evidenced  on, staff interview, facility d clinical record review it was by staff failed to provide the and services, consistent indards of practice, to event infection and prevent eloping for two of 51 ey sample, Residents #53  silled to assess, measure, esident #53's sacral pressure  alled to implement the revalon boots to off load int #98's feet. On 3/5/19, bserved in bed without the revalon boots in place.	F6	All other residents with wou prevention and treatment or potentially been affected. The ADON, QA nurse and/or Unwill conduct 100% skin aud audit of all Pressure injury proders to identify any reside alterations in skin integrity monitoring, assessment and missing prevention items. A findings will be corrected and discovery and disciplinary a indicated. A facility Incident Accident form will be compared to the facility Policy and Proc Wound Care has been reviet changes are warranted at the Wound Care nurse will reconstructed in the preform assessing, measuring, many tracking of pressure injuries skin integrity issues. All nurse inserviced by the Wound and/or the DON on the facility Procedure. The training the review and application ordered pressure relieving to	and care ders may have the DON, nit Manager dit and a 100% derevention ents at risk for without proper tracking and any negative and the time of action taken as at and deleted each  cedure for ewed and no dis time. The eive 1:1 oper procedure nonitoring and s and other arsing staff will d Care Nurse dility's Pressure ention Policy g will include of physician		

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F 686	disc disease [disc disc characterized by the one or more of the disof the spine (3)], and chronic, nonreversible a combination of emphronchitis (4)].  The most recent MDS assessment, a quarter assessment reference the resident as scoring interview for mental swas moderately imparted decisions. The resident completely dependent members for all of the Section M - Skin Corcoded as not having During the entrance approximately 6:30 paralist of all residents.  A "Wound and Skin Statistical and Skin Statistical and Skin Statistical and service approximately 6:30 paralist of all residents.  The clinical record was noted dated 2/6/19 at part, "Resident obset X (by) 0.5 W (width)	sease is a common condition breakdown [degeneration] of scs that separate the bones COPD [general term for e lung disease that is usually	F 68	Monitoring: The DON is responsible for cor The DON, ADON and/or QA n review all residents weekly skir inspection sheets to identify any with a potential skin alteration requires assessment, measuring and monitoring. The DON, AT QA nurse will complete 3 rand weekly to monitor for physicia preventive pressure injury dev place. Any/all negative finding addressed at time of discovery additional inservice training are disciplinary with will be admit that time. The results of the assent to the Quality Assurance monthly for review, analysis, recommendations for change policy, procedure, and/or prace Completion Date: April 17,	y residents that y, tracking OON and/or lom rounds in ordered ices are in gs will be y and ind/or nistered at udits will be Committee and in facility etice.	

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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	· · · · · · · · · · · · · · · · · · ·	ULD BE	(X5) COMPLETION DATE
F 686	Review of the Would 2/8/19, documented Illness: She has an of the right buttock. There is moderate exudateUnstagearight buttock. Etiolox 1.3 x not measura. The Wound Specia documented in part Necrosis) of the right Wound size: 1.6 x 1 (including biofilm) 1  The care plan did nure "Problem onset." The for skin breakdown "Approaches" was as skin for signs or syndowns document at doctor) as needed. Ordered. Treatment Dated 2/7/19, "Tx (the Arequest was madd 3:00 p.m., to ASM (all 1, the administration of the right buttock. No fur provided.  An interview was controlled the provided.  An interview was controlled the location in the cassessment, measurant in the cassessment, measurant in the cassessment, measurant in the cassessment in the casses in the location in the case in the locat	In d Specialist's notes dated in part, "History of Present unstageable (due to necrosis) of at least 1 days duration. Serosanguinous ble (Due to necrosis) of the gy: Pressure; Wound size: 1.6 lible. Slough: 100%."  Ilist's notes dated 2/22/19, "Unstageable (Due to nt buttock. Etiology: pressure, .3 x not measurable, Slough 00%."  In the "Problem/Need: Potential due to incontinence." Under documented in part, "Assess and report to md (medical Air mattress to bed as as orders per physician."  In the on 3/6/19 at approximately administrative staff member) or, and ASM #3, the regional or any measurements and the wound on the resident's ther documents were	F 6	:86		

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495353	B. WING	i			C <b>06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP O 900 S MAIN ST BLACKSTONE, VA 23824	CODE	<u> </u>	00/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 686	#53's right buttocks oversight. I didn't s of wound doctor's) request was made #53.  An observation of I with LPN #10 and I unit manager on 3/buttock was observed be healed. At this to oversight on my particular measuring the wound. An interview was cop.m. with ASM #6, When asked to des Resident #53's woundly sees the residualess she has a notare. She stated the skin. She and the fewer can to prevent a everything they try, stated that the residual end of the wound, ASM #6 stated that the residual end of the wound, ASM #6 stated that a new wouther right buttock at the facility policy, "Breakdown - Clinicipart, "2. In addition,"	ee that documented in (name notes. It's an oversight." A to see the wound of Resident Resident #53 was conducted RN (registered nurse) #3, the 6/19 at 4:58 p.m. The right red. The wound was noted to ime LPN #10 stated, "It was an rt (for not tracking and and). It was my mistake."  Inducted on 3/6/19 at 5:50 the wound care specialist. Scribe her involvement with unds, ASM #6 stated that she ent every three to four weeks ew area. She is on hospice at this resident has very fragile acility have tried as much as and heal her wounds. With she still breaks down. She dent and responsible party has nt of the wounds. They have rventions and she refuses breaks down. When asked aware of the right buttock ated, "According to my notes, it ler again on 2/22/19 because and on her sacrum. I looked at	F	686			

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

Event ID: 82QJ11

Facility ID: VA0108

If continuation sheet Page 84 of 131

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MAR 2 9 2019

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495353	B. WING			C <b>/06/2019</b>	
	PROVIDER OR SUPPLIER	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824	, , , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC  X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 686	necrotic tissue." The facility, did not addrand measuring of the Administrative staff administrator, ASM consultant, and ASI president of operation above findings on 3 p.m.  On 3/6/19 at 8:15 pnursing, was asked of practice the facility follow their policies. No further information Non-Medical Reade Chapman, page 28 (2) This information following website: https://medlineplus. (3) This information following website: https://ghr.nlm.nih.gc-disease.  (4) Barron's Diction Non-Medical Reade Chapman, page 12  2. The facility staff of physician ordered Epressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure on Reside Resident #98 was consulted to the pressure of Resident #98 was consult	presence of exudates or e policy presented by the ress the tracking, monitoring ne wounds, once found.  member (ASM) #1, the #3, the regional nurse M #4, the regional vice ons, were made aware of the M/6/19 at approximately 6:00  .m. ASM #2, the director of which professional standard try follows, ASM #2 stated they and Lippincott."  fon was provided prior to exit.  ary of Medical Terms for the er, 5th edition, Rothenberg and 6.  a was obtained from the gov/ency/article/000473.htm  a was obtained from the gov/condition/intervertebral-diseary of Medical Terms for the er, 5th edition, Rothenberg and form the gov/condition/intervertebral-diseary of Medical Terms for the er, 5th edition, Rothenberg and	F6	886			

	OF CORRECTION	IDENTIFICATION NUMBER:		NG		TE SURVEY MPLETED
		495353	B. WING		03	C <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		700,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 686	but were not limited Pressure, and Depri Minimum Data Set with an Assessmen 01/18/2019 coded F cognitive impairmer Data Set coded Reassistance of one sidaily living and total feeding).  On 03/05/2019 at a Resident #98 was oright side, under a lifet exposed. Resident #98 was oback, under a light exposed. Resident #98 was reviewed. Resident #98's phys "Prevalon boots to be time" dated 01/18/2 Risk Assessment Resident "Risk score 01/18/2019. Reside boots on when obsea.m. and at 1:59 p.r.	admitted to the facility on bees for Resident #98 included to Heart Failure, High Blood ression. Resident #98's (significant change in status) to Reference Date of Resident #98 with severe at. In addition, the Minimum sident #98 as requiring total taff member with activities of dependence for eating (tube approximately at 8:40 a.m., observed lying in bed, on her light green colored blanket with lent #98 had on gray socks propped up on a pillow.  In a proximately 1:59 p.m., observed lying in bed, on her light green colored blanket with feet lend alon gray socks and lend alon gray socks and lend the propped up on a pillow.  In a proximately 1:59 p.m., observed lying in bed, on her green colored blanket with feet lend alon gray socks and lend the propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed lying in bed, on her green colored blanket with feet lend and the propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.  In a proximately 1:59 p.m., observed propped up on a pillow.	F 6	86		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495353	B. WING			l	06/2019	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZII	PCODE	1 03/	30/2019	
HERITAC	GE HALL BLACKSTO	NE		BLACKSTONE, VA 23824				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	1	ON SHOULD HE APPROPI	BE	(X5) COMPLETION DATE	
F 686	back, under a light covered. LPN #4 (Lasked to remove Reboth feet. Resident propped up on a pil wearing prevalon be #98, "Where are yo # 98 did not responsesident's prevalon and placed the book An interview was coapproximately 10:23 Nurse) #1 (Unit Man what the purpose of stated that the purpensure resident get asked how staff ensbeing followed. RN orders and make roin place or are being aware of Resident # boots as ordered. For prevalon boots. For pressure. RN #1 staresident was wearing looking at her order On 03/06/2019 at a (Administrative Staff ASM #3 (Regional Net 19 (Regional Vice Pmade aware of finding No further information.)	pserved lying in bed, on her green colored blanket with feet icensed Practical Nurse) was esident #98's blanket to reveal #98's feet were observed low and the resident was not pots. LPN #4 asked Resident ur prevalon boots?" Resident d. LPN #4 then located the boots behind the television its on Resident #98's feet.  Inducted on 03/06/2019 at 3 a.m. with RN (Registered hager). RN #1 was asked if physician orders. RN #1 ose of physician orders was to so the care needed. RN #1 was soure physician orders are #1 stated that he reviews the bunds to ensure things are in greated to ensure things are in greated that he made sure the great	F6					

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353	B. WING			03/06/2019	
	ROMDER OR SUPPLIER  HALL BLACKSTONE			90	REET ADDRESS, CITY, STATE, ZIP CODE 10 S MAIN ST LACKSTONE, VA 23824		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 686 F 689 SS=D	information was obta https://www.ncbi.nlm Free of Accident Haz CFR(s): 483.25(d)(1) \$483.25(d) Accidents The facility must ens \$483.25(d)(1) The reas free of accident his \$483.25(d)(2)Each resupervision and assi accidents. This REQUIREMENT by:  Based on observation record review, it was staff failed to implem accidents per the phresidents in the surv. The facility staff faile each side of Reside prevention per the cophysician order on 0. The findings include Resident #98 was a 12/17/2018. Diagnoobut were not limited Pressure, and Depressure, and Depressure, and Depressure, and Depressure of the Minimum Data Set (Reference Date of 0.498 with severe cog the Minimum Data Set (Reference Date).	ined from the website: .nih.gov/pubmed/25608538 ards/Supervision/Devices (2)  ure that sident environment remains azards as is possible; and esident receives adequate stance devices to prevent  T is not met as evidenced on, staff interview, and clinical determined that the facility ment interventions to prevent ysician order for one of 51 ey sample, Resident #98 and to implement fall mat(s) on int #98's bed for fall comprehensive care plan and 13/05/2019.  : dmitted to the facility on ses for Resident #98 included to Heart Failure, High Blood ession. Resident #98's MDS) with an Assessment 11/18/2019 coded Resident initive impairment. In addition, Set coded Resident #98 as tance of one staff member		686	Corrective Action(s): Resident #98's attending physician been notified that facility staff failed ensure a physician ordered fall mat place on both sides of the bed as ord A facility incident and accident for been completed for this incident.  Identification of Deficient Practices/Corrective Action(s): All other residents with physician of fall mats or other preventive device prevent falls and injury may have be potentially affected. The DON, AL and/or Unit Manager will conduct review of all residents with physiciordered fall mats and fall preventive devices to identify residents at risk inconsistent application of the equal All residents identified at risk will corrected at time of discovery and Incident & Accident form will be completed for each negative finding attending physician will be notified each incident.  Systemic Change(s): The facility policy and procedure prevention and management has be reviewed and no revisions are was at this time. The DON and/or regulated for each negative finding use of and application of fall prevention of fall preventions and procedure prevention and management has be reviewed and no revisions are was at this time. The DON and/or regulated for each negative finding use of and application of fall preventions are was at this time. The DON and/or regulated for each negative finding use of and application of fall preventions are was at this time. The DON and/or regulated for each negative finding use of and application of fall preventions are was at this time. The DON and/or regulated for each negative finding use of and application of fall preventions are was at this time. The DON and/or regulated for each negative finding use of and application of fall preventions are was at this time. The dollar finding use of and application of fall preventions are was at the selection of the each negative finding use of and application of fall preventions.	ordered es to been book a 100% ian on c for ipment. be an mg. The ed of for fall been rranted ional l proper vention and	
	the Minimum Data S requiring total assist	Set coded Resident #98 as	4-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1-1		use of and application of fall prev	vention ind	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		495353	B. WING_				06/2019	
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
(0.00.07 )					900 S MAIN ST			
HERITAGE	HALL BLACKSTONE			ı	BLACKSTONE, VA 23824			
0/0.15	TO VOLKAMI IO	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ı	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	COMPLETION DATE	
F 689	Continued From page	e 88	F	689	Wanitaning:			
,	for eating (tube feedi				Monitoring: The DON is responsible for maintage.	ining		
	Tot cating (tabe teed)	··9 <i>)</i> ·			compliance. The DON and/or Unit			
	On 03/05/2019 at ap	proximately at 8:40 a.m.,			Manager will perform daily inspec			
		served lying in bed, on her			all residents with physician order f			
		tht green colored blanket with			prevention devices to monitor for			
	feet exposed. One fa	all mat was observed on the			compliance. Any/all negative findi			
	left side of Resident	#98's bed on the floor.			will be corrected at time of discove disciplinary action will be taken as	,		
	On 03/05/2019 at ap	proximately 1:59 p.m.,			needed. Aggregate findings of the			
	Resident #98 was of	served lying in bed, on her			reviews will be reported to the Qu			
		reen colored blanket with feet			Assurance Committee quarterly fo			
	, ,	at was observed on the left			review, analysis, and recommenda for change in facility policy, proce	dure dure	!	
	side of Resident #98	's bed on the floor.			and/or practice.			
	On 03/05/2019, Res	ident #98's clinical record	1		Completion Date: April 17, 2019			
		lent #98's care plan dated						
		ed, "Fall mat times two to						
		and Resident #98's physician						
	F .	018 documented, "Fall mat to						
	each side of bed for	safety."						
	Resident #98's fall ri	isk assessment dated						
		nted a total score of 12. The						
	fall risk assessment	dated 02/11/2019 stated a						
	score of 10 or highe	r indicates HIGH RISK for						
		protocol should be initiated						
	immediately and do	cumented on the care plan.						
	l .	nducted on 03/06/2019 at						
		a.m. with RN (Registered						
		nager). RN #1 was asked						
		of fall mats. RN #1 stated that						
		nats are fall interventions put						
		falls. RN #1 was asked how						
		s are in place. RN #1 stated le to ensure that fall mats are						
	, ,	made aware of Resident #98 ton both sides of the bed. RN						
		rected the issue after						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495353	B. WING_			03/0	6/2019
*	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824			
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	reviewing the orders On 03/06/2019 at ap (Administrative Staff ASM #3 (Regional N	and care plan.  proximately 12:30 p.m., ASM  Member) #1 (Administrator),  urse Consultant), and ASM  esident of Operations) were	F	689			
F 690	Bowel/Bladder Incon CFR(s): 483.25(e)(1) §483.25(e)(1) The faresident who is conti- admission receives of maintain continence condition is or becor- not possible to main §483.25(e)(2)For an incontinence, based comprehensive asse- ensure that- (i) A resident who er- indwelling catheter is resident's clinical co- catheterization was (ii) A resident who er- indwelling catheter is assessed for rem- as possible unless to demonstrates that co- and (iii) A resident who is receives appropriate	tinence, Catheter, UTI  l-(3)  lence.  licility must ensure that ment of bladder and bowel on services and assistance to unless his or her clinical mes such that continence is tain.  lesident with urinary on the resident's lessment, the facility must  leters the facility without an as not catheterized unless the indition demonstrates that mecessary; mers the facility with an or subsequently receives one loval of the catheter as soon he resident's clinical condition atheterization is necessary; as incontinent of bladder the treatment and services to the infections and to restore dent possible.	F	690	Corrective Action(s): Resident #45's catheter drainage has now anchored per policy and procensure the catheter collection bag collection tubing is off the floor to prevent infection and injury. The resident's care plan has been revisive reflect accurate Suprapubic cathet to include proper placement of the drainage bag and tubing.  Identification of Deficient Practical Action(s): All other residents with a Foley of pubic catheter may have been posificated. The DON, ADON and Manager will conduct a 100% reall residents with a Foley and/or Suprapubic catheter to identify mat risk. Residents identified will corrected at time of discovery and disciplinary action with be taken warranted. a Facility Incident & Form will be for each negative for the suprapulation of the suprapulation of the suprapulation with the taken warranted.	edure to and of and of sed to the care e e e e e e e e e e e e e e e e e e	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495353	B. WING			03/	06/2019
	ROVIDER OR SUPPLIER  HALL BLACKSTONE	,		90	TREET ADDRESS, CITY, STATE, ZIP CODE 00 S MAIN ST BLACKSTONE, VA 23824		
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 690	incontinence, based comprehensive asse ensure that a resider receives appropriate restore as much norr possible. This REQUIREMEN' by: Based on observation record review, it was failed to provide care suprapubic catheter infections for one of sample, Residents # The facility staff faile catheter collection bresting on the floor. The findings include  Resident # 45 was a 07/29/14 and a readiagnoses that inclure retention of urine, urbenign prostatic hyp (3) and hypertension  Resident # 45's mosset), a 30-day asses (assessment references Resident # 45 as so interview for mental - 15, 9 (nine) - being cognition for making 45 was coded as be staff member for acceptance.	on the resident's ssment, the facility must at who is incontinent of bowel treatment and services to mal bowel function as  If is not met as evidenced on, staff interview and clinical determined that facility staff and services for a to prevent urinary tract 51 residents in the survey 45.  If the determined that facility staff and services for a to prevent urinary tract 51 residents in the survey 45.  If the determined that facility on the survey 45 and tubing were not limited to the facility on the determined that facility on the determined that facility on the determined that facility on the survey 45 and 45	F	690	Systemic Change(s): The facility Policy and Procedure for Foley/Suprapubic Catheter usage a Foley/Suprapubic Catheter Care has reviewed and no changes are warrathis time. The nursing staff will be inserviced by the DON on the policy procedures for proper Foley/Supray Catheter care to include the proper anchoring of catheter tubing and public placement of the drainage bag to poinfection and injury.  Monitoring: The Director of Nursing is responsional maintaining compliance. The DON Unit Manager will make daily rand audits of all Foley/Suprapubic Catheter tubing and proper placement of drainage to monitor compliance. All infindings will be corrected at time of discovery. Detailed findings of the will be reported to the Quality Ass Committee for review, analysis, as recommendations for change in fa policy, procedure, and/or practice. Completion Date: April 17, 2019	nd as been anted at  cy and pubic  roper revent  sible for I and/or dom heter's ng of ainage egative of is audit surance nd cility	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		l ` ´	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
	:	495353	B. WING _		C 03/06/2019		
	PROVIDER OR SUPPLIER GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824	1 03/	100/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 690	as "A. Indwelling cacatheter [5] and nep On 03/05/19 at 10:2 Resident # 45 revea Observation of the revealed it was han bed. Further observation bag and a section of directly on the floor.  On 03/05/19 at 10:2 conducted with Ressurveyor entered Restated she had just medication. After e45 was observed sire of the catheter collection of the observation bag and the observation of the observation observation of the observation of the observation of the observation observation observation observation observation observation o	atheter (including suprapubic phrostomy tube)."  27 a.m., an observation of aled the resident lying in bed. Catheter collection bag ging off the right side of the vation of the catheter ubing revealed the collection of the tubing was resting  49 a.m., an interview was sident # 45. Before this esident # 45's room, a nurse administered Resident # 45's ntering the room Resident # tting up in bed. Observation action bag revealed it was taken side of the bed. Further eatheter collection bag and collection bag and a section esting directly on the floor.  20 a.m., an observation of aled the resident lying in bed. Catheter collection bag ging off the right side of the vation of the catheter ubing revealed the collection of the tubing was resting  1's order sheet) for Resident # 19" documented, "Foley heck catheter anchor	F 69				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1`′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495353	B. WING			C 03/06/2019	
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F 690	The comprehensive dated 06/08/2015 d Colostomy and indu Under "Approaches Foley catheter / Fol On 03/06/19 at 9:05 interview of Reside bag and tubing was (registered nurse) # surveyor into Resid placement of Resid bag and catheter tu catheter collection bag and of floor. RN # 3 stated the floor." When as collection bag and of the floor, RN # 3 stated the floor, RN # 3 stated placement of the bat touch the floor." W catheter collection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter collection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter collection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter collection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter collection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter collection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter tollection bag and catheter collection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter tollection bag and of floor, RN # 3 stated placement of the bat touch the floor." W catheter tollection bag and of floor, RN # 3 stated placement of the bat touch the floor."	care plan for Resident # 45 ocumented, "Problem/Need: velling urinary catheter." it it documented, "Change ey bag as ordered." is a.m., an observation and at # 45's catheter collection conducted with RN is 3. RN # 3 accompanied this ent # 45's room to observe the ent # 45's room to observe the ent # 45's catheter collection bing. Upon observing the 45's pag and catheter tubing RN # 45's bed until the catheter catheter tubing was off the did, "It should not be touching sked why the catheter eatheter tubing should be off ated, "To prevent infection." he facility ensures the catheter tubing are kept off the grand tubing so it doesn't hen asked how often the pag and catheter tubing is lent, RN # 3 stated, "It should CNAs (certified nursing sees are checking on patient."  "Catheter Care, Urinary" tion Control. 2. Maintain en handling or manipulating or drainage bag. b. Be sure and drainage bag are kept off	F 6	90			

STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
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	OVIDER OR SUPPLIER HALL BLACKSTONE			90	REET ADDRESS, CITY, STATE, ZIP CODE DIS MAIN ST LACKSTONE, VA 23824	***************************************	
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F 690	consultant, were made No further information References: (1) An infection in the information was obtainttps://www.nlm.nih.go00521.htm.  (2) An enlarged prosoptained from the weather the weather than the information was obtained to make the amount information was obtained from the weather than the information wa	M # 3, regional nurse the aware of the findings. In was provided prior to exit. In was provided prior the website: In which the body cannot of sugar in the blood. This wined from the website: In which the website: In which the body cannot of sugar in the blood. This wined from the website: In which the provided prior to exit. In was provid	F	690	DEFICIENCY)		
1	CFR(s): 483.25(g)(4)-(5) Er (Includes naso-gast both percutaneous of percutaneous endos enteral fluids). Base comprehensive ass ensure that a reside	nteral Nutrition ric and gastrostomy tubes, endoscopic gastrostomy and scopic jejunostomy, and d on a resident's essment, the facility must	F	693	F693 Corrective Action(s): Residents #151's attending physic has been notified that facility staff not properly label resident #151's feeding with name, rate of feeding and time the tube feeding was star facility Incident & Accident form been completed for this incident.	f did tube g, date ted. A	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495353	B. WING_			] 03	06/2019	
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F 693	enteral methods u condition demonst clinically indicated resident; and §483.25(g)(5) A re means receives the	or with assistance is not fed by nless the resident's clinical rates that enteral feeding was and consented to by the esident who is fed by enteral the appropriate treatment and		693	All other tube-feeding residents have been potentially affected. A review of all tube-feeding resident performed to identify those at rinegative findings will be correct the time of discovery and a facil Incident & Accident form will be completed for any/all negative f	may A 100% ents was sk. Any ed at ity		
	and to prevent cor including but not li diarrhea, vomiting abnormalities, and This REQUIREME by: Based on observ record review, it w failed to provide a services to prevent feeding for one of sample, Resident				Systemic Change(s): The facility Policy and Procedur reviewed and no changes are was at this time. All licensed staff winserviced by the DON and/or the Regional Nurse Consultant on the facility policy and procedure for labeling, administering and the changing and of physician order feedings, as well as proper documentation for tube-feedings.	re was uranted ill be ne ne ed tube-		
	G-tube (1) feeding rate of feeding, R number, and the started.  The findings inclu The facility staff for G-tube (1) feeding name, rate of fee identification numfeeding was start  Resident # 151 w 01/26/04, with a resident of feeding was start.	ailed to label Resident # 151's g with the Resident # 151's ding, Resident # 151's ber, and the date and time, the			Monitoring: The DON is responsible for compliance. The DON and/or U Managers will perform 2 random feeding audits weekly to monitor compliance. All negative finding identified during the audit will be corrected at time of discovery an appropriate disciplinary action to Detailed findings of these review be provided to the Quality Assur Committee for review, analysis, recommendations for change in policy, procedure, and/or practice Completion Date: April 17, 20	n tube r for gs e nd aken. ws will rance and facility ee.		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ł	TIPLE CONSTRUCTION	1	(X3) DATE SURVEY COMPLETED		
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F 693	dysphagia (2), cere gastrostomy (5).  Resident # 151's m data set), a quarter (assessment refere Resident # 151 as interview for menta - 15, 3 (three) - bein cognition for making 151 was coded as a staff member for ac K "Swallowing/Nutri # 151 as having a "resident."  On 03/05/19 at 10:0 Resident # 151 revened of the bed was observed receing a pole next to the big of the date and time of the date and time on 03/05/19 at 11:0 Resident # 151 revened of the bed was observed receing. Resident # and the date and time on 03/05/19 at 11:0 Resident # 151 revened of the bed was observed receing. Observation of Resident # 151 revened of the bed was observed receing. Observation of Resident # 151 revened of the bed was observed receing. Observation of Resident # 1500-milliliter bag of pole next to the bed G-tube, to Resident hour. Observation of the servation of Resident # 150-milliliter bag of pole next to the bed G-tube, to Resident hour. Observation of the servation of the servation. Observation of the servation of the servation of the servation of the servation of the servation. Observation of the servation of the ser	bral palsy (3), anemia (4) and ost recent MDS (minimum ly assessment with an ARD ence date) of 02/22/19, coded scoring a 3 (three) on the brief I status (BIMS) of a score of 0 ng severely impaired of g daily decisions. Resident # being totally dependent of one ctivities of daily living. Section itional Status" coded Resident Feeding tube. While a 0.7 a.m., an observation of ealed she was in bed, the selevated and the resident wing a tube feeding. ident # 151's room revealed a of "Fibersource (6)" hanging on ed, being infused through a transfer # 151 at 45 milliliters per of the Fibersource bag failed in the feeding was started. On a.m., an observation of ealed she was in bed, the selevated and the resident wing a tube feeding. In the feeding was started and the resident wing a tube feeding. It is room revealed a feeding infused through a transfer # 151's room revealed a feeding infused through a transfer # 151 at 45 milliliters per of the Fibersource bag failed in the Fibersource b	F6	93				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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F 693	feeding, Resident # and the date and tir  On 03/05/19 at 12:5 Resident # 151's tul Fibersource was tal  The POS (physiciar 2019" documented, (calories) Liquid, 45 (hour) via peg X (tin (4:00 p.m.) and off 1/15/18."  On 03/05/19 at 12:5 conducted with LPN 6. When asked aboride in the calories of the conducted with the fibersource, LPN #	151's identification number, ne the feeding was started.  50 p.m., an observation of be feeding revealed the bag of ken down.  1's order sheet) dated "March "Fibersource 1.2 CAL cc (cubic centimeters)/ hr nes) 20 hours. On at 1600 1200 (12:00 p.m.). Start Date  15 p.m., an interview was I (licensed practical nurse) # out Resident # 151's bag of 6 stated she had taken it	F 69			
	medication cart. LP the feeding bag fror could be examined. plastic gloves and re container. An obser Fibersource feeding The observation rev bag of Fibersource 151's name, rate of identification number feeding was started the label on the bag # 6 stated, "After I d put the information of describe the proced resident's bag of tub should have the resibed, date and order	In the trash container on the N # 6 was asked to remove in the trash container so it LPN # 6 put on a pair of emoved it from the trash roation of the bag of was conducted with LPN # 6. realed that the label on the was filled in with Resident # feeding, Resident # 151's er, and the date and time the When asked who filled in of Fibersource feeding, LPN id the flush at about 11:30 I on the bag." When asked to ure of documenting on a pe feeding, LPN # 6 stated, "It ident's name, room number, for the infusion." When e for Resident # 151's tube				

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 693	(4:00 p.m.) and it is p.m., noon) each da label on Resident # should have been fi "Yesterday at 4 p.m. LPN # 7 would have feeding for Resident p.m.  On 03/05/19 at 3:37 conducted with LPN describe the process feeding, LPN # 7 stamake sure it is the rispike it and prime in the air out of the tult with feeding, check flush with water, corpatient's name, date attach tubing to g-tusettings and start the often the process sl LPN # 7 stated, "The new bag is hung." When the proper time at t	ge 97 ated, "It's started at 4 p.m. cut off (stopped) at 12 (12:00 ay." When asked when the 151's bag of tube feeding illed in, LPN # 6 stated, ." LPN # 6 further stated that e started the new bag of tube at # 151 on 03/04/19 at 4:00  7 p.m., an interview was I # 7. When asked to as for starting a resident's tube ated, "Check the orders to right feeding for the resident. It through the pump to push bing and make sure it is filled placement with stethoscope, mplete the label provided with the time and rate of feeding, abe, clear volume and check are feeding." When asked how are described is completed are process is done each time a When asked why the label at, LPN # 7 stated, "To make getting the proper feeding at the proper rate and it is the asked about Resident # # 7 stated, "I hung her bag " When asked if she asked if she asked if she asked abel on the bag and to 7 stated, "I would hope I d of the observations of the label on the tube-feeding bag T did not have a comment.  Enteral Feedings - Safety	F 69			
***************************************	Precautions" docum	ented, "Preventing errors in				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 693	administration. 2. Cinitials, date and timhung/administered, checked against the On 03/05/19 at app (administrative staff administrator and A consultant, were many the foliation of the stomath of a feed the stomach wall. It stomach. This inforwebsite: https://medlineplus  (2) A swallowing disobtained from the whoth the whole of the stomach wall. It stomach. This inforwebsite: https://www.nlm.nih.sorders.html.  (3) A group of disordability to move and the posture. This informwebsite: https://www.nlm.nih.y.html.  (4) Low iron. This in the website: https://www.nlm.nih.	On the formula label document he the formula was and initial that the label was a corder."  roximately 5:15 p.m. ASM member) # 1, the SM # 3, regional nurse ade aware of the findings.  on was provided prior to exit.  eeding tube insertion is the ling tube through the skin and goes directly into the mation was obtained from the gov/ency/article/002937.htm.  order. This information was rebsite:  .gov/medlineplus/swallowingdiders that affect a person's to maintain balance and nation was obtained from the gov/medlineplus/cerebralpals  formation was obtained from .gov/medlineplus/anemia.html	F 6	693			
	(b) A gastrostomy fe placement of a feed	eeding tube insertion is the ing tube through the skin and				THE PROPERTY OF THE PROPERTY O	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 693 Continued From page 99 the stomach wall. It goes stomach. This information website: https://medlineplus.gov/e  (6) Nutritionally complete feeding formula for normand/or protein requirement was obtained from the website healths ource/fibersource-hn-hcp Respiratory/Tracheostom CFR(s): 483.25(i)  § 483.25(i) Respiratory of tracheostomy care and tracheostomy care and tracheostomy care and tracheostomy care, in care and tracheost with protopractice, the comprehens care plan, the residents' and 483.65 of this subpate this REQUIREMENT is by: Based on observation, reinterview, facility document record review, it was det failed to respiratory care 51 residents in the surve #53, #119, #145, #117, at 1. The facility staff failed the physician order for R Resident #53 was observocasions without her physician oxygen in pla did not document staff re- did not document staff re-	directly into the on was obtained from the one obtained or elevated calorie onts. This information ebsite: science.us/brands/fibers on the obtained of the		695	F695 Corrective Action(s) Resident #53's attending physician been notified that the facility failed ensure oxygen was administered at times as ordered by the physician. Facility Incident & Accident form completed for this incident.  Resident #119, #145 and #90's atte physicians have been notified that facility failed to properly store thein Nebulizer masks when not in use. Nebulizer Masks and tubing has be replaced with a new one and all we dated and stored in a clear plastic when not in use. A facility Incident Accident form was completed for incident.  Resident #117 has had their oxyge concentrators thoroughly cleaned include the air filter. A facility Incident Accident form was completed incident.	to all A was ending the ir The een ere bag at & this	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X3) DATE SURVEY COMPLETED C			
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wearing the ophysician.  2. The facility mask in a same bulizer manext to the reuncovered diaster of the resident #14 3/5/19 during #145's nebulithe residents  4. The facility in Resident #Observations concentrator in a light gray  5. The facility nebulizer manultiple observations with the residents with the physician Resident #5 occasions with continuous of did not docuoxygen or all	y reside oxygen a staff far intary my skaff far intary my skaff far intary my staff far its separative mass of Resident's of Resident's of Resident's of Resident my staff far include and order in order	and notification to the and notification to the alled to store a nebulizer anner, Resident #119's observed sitting on a chair bed on top of a plastic bag ultiple observations.  Alled to ensure proper storage ulizer mask after use. On the observations, Resident sk was observed on top of a not stored in a bag.  Alled to maintain a clean filter axygen concentrator.  Alled to maintain a clean filter axygen concentrator.  Alled to maintain a clean filter axygen concentrator.  Alled to store Resident # 90's sanitary manner. During set the resident's nebulizer of the nebulizer machine	F	695	Identification of Deficient Practice & Corrective Action(s): All other resident receiving physicia ordered oxygen may have potentially been affected. A 100% review of all residents with physician ordered oxywas conducted to identify any/all residents at risk. Any negative finding were corrected at time of discovery new oxygen equipment was obtained dated and stored correctly as needed well as all concentrators were inspect for cleanliness. A facility Incident & Accident form will be completed for negative finding.  Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing swill be inserviced by the DON on the proper procedure for administering oxygen per physician order as well a proper cleaning, changing and storic Oxygen equipment to include cleanic concentrators and storage of nasal cannulas and nebulizer tubing and maken not in use.  Monitoring: The DON and/or Unit Manager is responsible for maintaining complia The DON or Unit Manager will make weekly rounds to monitor for compl Any negative findings will be correctime of discovery and disciplinary and maken of discovery and disciplinary a	ygen ngs and d and d. As cted & r each ss staff ne ng nasks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BUI		PLE CO	(X:	(X3) DATE SURVEY COMPLETED		
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F 695	2/24/17 with diagnost limited to: hypothyro of the thyroid gland) breakdown of muscle release of muscle fit. These substances a often cause kidney of disc disease (disc disease (disc disease (disc disease) one or more of the of the spine) (3), and chronic, nonreversit a combination of embronchitis) (4).  The most recent ME assessment, a quarassessment referenthe resident as scor interview for mental was moderately impedecisions. The residentembers for all of his Section O - Special Programs the residentembers for all of his Sect	dmitted to the facility on ses that included but were not id disease (decreased activity (1), rhabdomyolysis (is the se tissue that leads to the per contents into the blood. The harmful to the kidney and damage) (2), degenerative isease is a common condition to breakdown (degeneration) of discs that separate the bones of COPD (general term for ble lung disease that is usually aphysema and chronic the breakdown (because that is usually aphysema and chronic ble lung disease tha		95	will be taken as warranted. All ne findings will be reported to the Q Assurance Committee for review, analysis, and recommendations for change in facility policy, procedurand/or practice.  Completion Date: April 17, 201	uality or ire,		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED	
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F 695	on 3/5/19 at 12:33 pasleep. The oxygen and the tubing was on the resident.  The third observation at 3:42 p.m. revealed oxygen via a nasal oprongs that insert in The physician order "O2 (oxygen) at 2L/continuous."  The comprehensive 12/21/18, document Resident is non-continuous. The comprehensive 12/21/18, document Resident is non-continuous part of the part of the part of the part of the nurse evidence document and report of the nurse evidence document resident with wearing to the physician.  An interview was continuous practical nurse	on was made of Resident #53 o.m. The resident was in bed concentrator was running still hanging off the tubing, not on of Resident #53 on 3/5/19 ed the resident receiving her cannula (a tubing with two	F 69	95		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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F 695	eat or drink with it of I've seen it on her." shared with LPN #9 aide must not have has to have her oxy have it on, her sats her blood) can drop sitting in her room so the state of the st	ake it off. She claims she can't n. Yesterday was the most The observations above were LPN #9 stated, "The hospice put it on her after care. She gen on. When she doesn't (oxygen saturation levels in to 89 - 90%. When she's he is normally 90-91%."  Inducted with RN (registered when asked oxygen is at #53, RN #3 stated, "Yes, PL/min." When asked if the n at all times, RN #3 stated, ctor's order."  Dxygen Administration"  "7. Observe the resident todically thereafter to be sure	F 69	95			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	TPLE CONSTRUCT	(X3) DA	(X3) DATE SURVEY COMPLETED		
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	PROVIDER OR SUPPLIER	NE		STREET ADDRESS 900 S MAIN ST BLACKSTON			100/2019
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F 695	members."  Administrative staff administrator, ASM consultant, and ASM president of operatinabove findings on 3 p.m.  On 3/6/19 at 8:15 p. nursing, was asked of practice the facilitifollow their policies  No further information (1) Barron's Dictional Non-Medical Reader Chapman, page 286 (2) This information following website: https://medlineplus.eq(3) This information following website: https://ghr.nlm.nih.gc-disease.  (4) Barron's Dictional Non-Medical Reader Chapman, page 124  2. The facility staff famask in a sanitary in nebulizer mask was next to the resident's uncovered during medical Resident #119 was a sesident #119 was a sanitary in Resident #119 was a s	member (ASM) #1, the #3, the regional nurse M #4, the regional vice ons, were made aware of the /6/19 at approximately 6:00 m. ASM #2, the director of which professional standard by follows, ASM #2 stated they and Lippincott."  on was obtained prior to exit.  ary of Medical Terms for the r, 5th edition, Rothenberg and 6.  was obtained from the gov/ency/article/000473.htm was obtained from the ov/condition/intervertebral-disery of Medical Terms for the r, 5th edition, Rothenberg and l.  ailed to store a nebulizer manner, Resident #119's observed sitting on a chair is bed on top of a plastic bag	F 6	95			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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MAMEORI	PROVIDER OR SUPPLIER	493333	D. WING		03/	/06/2019
	GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
11	limited to: depressic lung cancer, shortne [general term for che disease that is usual emphysema and che The most recent MI assessment, a Med with an assessment coded the resident at (brief interview for me the resident was calcognitive decisions. requiring limited to estaff member for he Section O - Special Programs, the resid respiratory services.  An observation was room on 3/4/19 at 65 machine and mask of the bed. The mask of the bed was still noted to be the chair. When ask of the chair. When ask Resident #119 states and observation was in Resident #119 states.  An observation was in Resident #119 states are this time. When ask nebulizer mask in the chair was in the stime. When as the stime was collaboration was in Resident #119 states.	on, alcohol use, pneumonia, ess of breath and COPD ronic, nonreversible lung ally a combination of ronic bronchitis (1)].  OS (minimum data set) icare 30 day assessment, reference date of 2/27/19, as scoring a "14" on the BIMS nental status) score, indicating pable of making daily. The resident was coded as extensive assistance of one ractivities of daily living. In Treatments, Procedures and ent not coded for any.  made of Resident #119's 136 p.m. The nebulizer were sitting on a chair next to was sitting on top of a plastic hen was the last time it was 9 stated she had had her m.  made of Resident #119's 52 a.m. The nebulizer mask sitting on the plastic bag on ed when it was used last,	F 6	95 ·		

NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL BLACKSTONE  STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824  [X4) ID PREFIX TAG  [EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 695  Continued From page 106  An observation was made of the nebulizer mask in Resident #119's room on 3/5/19 at 3:40 p.m. The nebulizer mask was in the bag, Resident #119 stated that she put it in the bag, not the staff.	C 03/06/2019 (X5) COMPLETION DATE
HERITAGE HALL BLACKSTONE  (X4) ID PREFIX TAG  F 695  Continued From page 106  An observation was made of the nebulizer mask in Resident #119's room on 3/5/19 at 3:40 p.m.  The nebulizer mask was in the bag, Resident #119 stated that she put it in the bag, not the	(X5) COMPLETION
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 695  Continued From page 106  An observation was made of the nebulizer mask in Resident #119's room on 3/5/19 at 3:40 p.m. The nebulizer mask was in the bag, Resident #119 stated that she put it in the bag, not the	COMPLETION
An observation was made of the nebulizer mask in Resident #119's room on 3/5/19 at 3:40 p.m. The nebulizer mask was in the bag. Resident #119 stated that she put it in the bag, not the	
in Resident #119's room on 3/5/19 at 3:40 p.m. The nebulizer mask was in the bag. Resident #119 stated that she put it in the bag, not the	**************************************
The physician order dated, 1/30/19, documented, "Albuteral Sul (solution) 1.25 MG/ML (milligrams/milliliters) sol (solution) (Albuterol is used to prevent and treat difficulty breathing, wheezing, shortness of breath, coughing, and chest tightness caused by lung diseases such as asthma and chronic obstructive pulmonary disease [COPD]) (2) - inhale 1 unit dose via jet neb (nebulizer) Q (every) 6 hours while awake."	
The comprehensive care plan dated, 1/30/19 and revised on 2/6/19, failed to evidence documentation regarding the use of nebulizers for the treatment of the resident's COPD.	
An interview was conducted with LPN (licensed practical nurse) #1 on 3/6/19 at 1:31 p.m. When asked how a nebulizer mask should be stored when not in use, LPN #1 stated it should be stored in a plastic bag when not in use. When asked why that is done, LPN #1 stated, "It's for sanitation reasons."	
An interview was conducted with RN (registered nurse) #3 on 3/6/19 at 1:33 p.m. When asked how a nebulizer mask should be stored when not in use, RN #3 stated, "It should be stored in a plastic bag with the resident's name and date it was changed." When asked why it should be stored in a plastic bag, "It's to keep it clean."  The facility policy, "Oxygen Admiration"	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
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		495353	B. WING			03/	06/2019	
	PROVIDER OR SUPPLIER GE HALL BLACKSTO	NE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E		(X5) COMPLETION DATE	
F 695	documented in part cannula/mask should bag when not in use Administrative staff administrator, ASM consultant, and ASM president of operation above findings on 3 p.m. At this time, ASM that the policy for the same for the oxygen	member (ASM) #1, the #3, the regional nurse M #4, the regional vice ons, were made aware of the /6/19 at approximately 6:00 SM #3 informed this surveyor e storage of nebulizers is the	F6	95				
	Non-Medical Reader Chapman, page 12-2 (2) This information following website: https://medlineplus.tml 3. The facility staff facesident #145's nebulizer matter residents dressed Resident #145 was 02/17/2017. Diagnosincluded but were new Pressure, Depressional Resident #145's Mirassessment) with an Date of 02/12/2019 moderate cognitive Minimum Data Set or requiring extensive as	ary of Medical Terms for the property of the edition, Rothenberg and 4.  was obtained from the gov/druginfo/meds/a682145.h ailed to ensure proper storage pulizer mask after use. On the edition of the e						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  GE HALL BLACKSTO	VE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	DE		00/2019
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F 695	assistance of one s On 03/05/2019 at a Resident #145's nel on top of the dresse a bag. On 03/05/2019 at a Resident #145's nel on top of the dresse a bag. On 03/06/2019, Res was reviewed. A phy 02/11/2019 docume Bromide/Albuterol S (milligrams)/3 ml (m treatment every four shortness of breath. comprehensive care to document informa mask. An interview was co approximately 10:23 Nurse) (Unit Manage the protocol was for equipment storage. cannula or mask sho when not in use. RN observations above of the resident's dres A copy of the facility nebulizer storage wa (Administrative Staff on 03/06/2019 at ap facility policy titled, "o	pproximately 8:40 a.m., bulizer machine was observed er, with the mask not stored in opproximately 1:59 p.m., bulizer machine was observed er, with the mask not stored in opproximately 1:59 p.m., bulizer machine was observed er, with the mask not stored in sident #145's clinical record ysician order dated nted, "Ipratropium bulfate 0.5-3 (2.5) mg illiliters) (1) give nebulizer r hours as needed for	F 6:	95			

F 695 Continued From page 109 should be stored in a clean, clear plastic bag when not in use."  On 03/06/2019 at approximately 6:00 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.  No further information was presented prior to exit.  References:  (1) A medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with diseases that affect the lung and airways. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.h tml  4. The facility staff failed to maintain a clean filter in Resident #117's oxygen concentrator. Observations of Resident #117's oxygen concentrator filter revealed the filter was covered in a light gray, dusty residue.  Resident #117 was admitted to the facility on 12/17/18. Resident #117's diagnoses included but were not limited to chronic kidney disease, hearf failure and dehydration. Resident #117's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD (assessment reference date) of 2/11/19, coded the resident as being cognitively inlact. Section O documented		AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED		
HERITAGE HALL BLACKSTONE  (XA) ID  (XA) ID  (XA) ID  (XA) ID  (XA) ID  (CACH DEPRICIANCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)  F 695  Continued From page 109 should be stored in a clean, clear plastic bag when not in use."  On 03/06/2019 at approximately 6:00 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vurse Consultant), and ASM #4 (Regional Vurse Consultant), and ASM #4 (Regional Vurse consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.  No further information was presented prior to exit.  References:  (1) A medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with diseases that affect the lung and airways. This information was obtained from the website: https://mediineplus.gov/drugirifo/meds/a601063.h tml  4. The facility staff failed to maintain a clean filter in Resident #117's oxygen concentrator. Observations of Resident #117's oxygen concentrator filter revealed the filter was covered in a light gray, dusty residue.  Resident #117 was admitted to the facility on 12/17/18. Resident #117's cliagnoses included but were not limited to chronic kidney disease, heart failure and dehydration. Resident #117's most recent MDS (minimum data see), a 60 day Medicare assessment with an ARD (assessment reference date) of 27/11/9, coded the resident as being cognitively intact. Section O documented			495353	B. WING			
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 695  Continued From page 109 should be stored in a clean, clear plastic bag when not in use.*  On 03/06/2019 at approximately 6:00 p.m., ASM (Administrative Staff Member) #1 (Administrative), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.  No further information was presented prior to exit.  References:  (1) A medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with diseases that affect the lung and airways. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.html  4. The facility staff failed to maintain a clean filter in Resident #117's oxygen concentrator. Observations of Resident #117's oxygen concentrator filter revealed the filter was covered in a light gray, dusty residue.  Resident #117 was admitted to the facility on 12/17/18. Resident #117's diagnoses included but were not limited to chronic kidney disease, heart failure and dehydration. Resident #117's dosygen concentrator follows from the service of the provious concentrator was covered in a light gray, dusty residue.  Resident #117 was admitted to the facility on 12/17/18. Resident #117's diagnoses included but were not limited to chronic kidney disease, heart failure and dehydration. Resident #117's oxygen concentrator follows from the resident as being cognitively intact. Section O documented			NE		900 S MAIN ST		
should be stored in a clean, clear plastic bag when not in use."  On 03/06/2019 at approximately 6:00 p.m., ASM (Administrative Staff Member) #1 (Administrator), ASM #3 (Regional Nurse Consultant), and ASM #4 (Regional Vice President of Operations) were made aware of findings.  No further information was presented prior to exit.  References:  (1) A medication used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with diseases that affect the lung and airways. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a601063.h tml  4. The facility staff failed to maintain a clean filter in Resident #117's oxygen concentrator. Observations of Resident #117's oxygen concentrator filter revealed the filter was covered in a light gray, dusty residue.  Resident #117 was admitted to the facility on 12/17/18. Resident #117's diagnoses included but were not limited to chronic kidney disease, heart failure and dehydration. Resident #117's most recent MDS (minimum data set), a 60 day Medicare assessment with an ARD (assessment reference date) of 2/11/19, coded the resident as being cognitively intact. Section O documented	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI)	( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETION
Resident #117 as receiving oxygen therapy.  Review of Resident #117's clinical record revealed a physician's order dated 12/23/18, for	F 695	should be stored in when not in use."  On 03/06/2019 at a (Administrative Staf ASM #3 (Regional N#4 (Regional Vice Pmade aware of finding No further information	a clean, clear plastic bag  pproximately 6:00 p.m., ASM f Member) #1 (Administrator), Nurse Consultant), and ASM President of Operations) were ings.  on was presented prior to exit.  ed to prevent wheezing, chest tightness, and coughing ses that affect the lung and ration was obtained from the gov/druginfo/meds/a601063.h called to maintain a clean filter exygen concentrator. Sident #117's oxygen evealed the filter was covered residue.  admitted to the facility on #117's diagnoses included to chronic kidney disease, mydration. Resident #117's ninimum data set), a 60 day ant with an ARD (assessment fall), coded the resident as fact. Section O documented ceiving oxygen therapy.	F6	95		

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495353	B. WING				C (06/2010
	PROVIDER OR SUPPLIER  GE HALL BLACKSTOR	NE		STREET ADDRESS, CITY, STATE, ZIP C 900 S MAIN ST BLACKSTONE, VA 23824	XODE	. 03/	06/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD	BE	(X5) COMPLETION DATE
F 695	Further review of phreveal any orders reconcentrator filter. comprehensive care to reveal documents concentrator filter.  On 3/5/19 at 8:30 a.m., #117's oxygen concentrator filter was cover residue.  On 3/6/19 at 10:28 a conducted with LPN (the nurse caring fo (registered nurse) # and RN #1 were ast cleaning oxygen constated, "I know that starting to get lint or rinse them out, clea #4 and RN #1 were concern. LPN #4 st dirty filter. LPN #4 st dirty filter. LPN #4 sits in a chair near the (LPN #4) can't geoncentrator. RN # filter.  On 2/6/19 at 3:41 p. conducted with RN sit (the filter). It was oxygen concentrator the filter each month.	nysician's orders failed to egarding the oxygen Resident #117's e plan dated 12/24/18, failed ation regarding the oxygen .m., 3/5/19 at 2:00 p.m., and observations of Resident entrator filter were conducted. ed in a light gray, dusty a.m., an interview was I (licensed practical nurse) #4 r Resident #117) and RN of (the unit manager). LPN #4 ked the facility process for incentrator filters. LPN #4 when I see that they are in the filter I take them off, in, dry and put back on." LPN made aware of the above sated she had not noticed the stated Resident #117 often the oxygen concentrator and get to the filter on the 1 was asked to observe the m., another interview was #1. RN #1 stated, "I cleaned rough." RN #1 stated the r vendor is supposed to clean	F6	95			

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

Event ID: 82QJ11

Facility ID: VA0108

If continuation sheet Page 111 of 131

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MAR 2 9 2019

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	TIPLE CONSTRUCTION NG	(X	(X3) DATE SURVEY COMPLETED		
		495353	B. WING				C 06/2019
	PROVIDER OR SUPPLIER  GE HALL BLACKSTOI	NE	***************************************	STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	DDE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 695	regional vice presid aware of the above  The facility policy tit failed to document if facility process for one of the facility staff in	ent of operations) was made concern.  Ied, "Oxygen Administration" information regarding the cleaning the concentrator filter.  On was presented prior to exit. failed to store Resident # 90's sanitary manner. During is the resident's nebulizer of the nebulizer machine  admitted to the facility on nitted on 4/29/16 with ided but were not limited to: pulmonary disease (1), and hypertension (3).  Ist recent MDS (minimum data essment with an ARD ince date) of 1/18/19, coded coring a 8 on the brief status (BIMS) of a score of 0 erately impaired of cognition isions. Resident # 90 was imited to extensive assistance living of one staff member reing totally dependent of one	F 6	95			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495353	B. WING			С		
NAME OF I	PROVIDER OR SUPPLIER	490000	D. WING	STREET ADDRESS, CITY, STATE, ZIP		03/06/2019		
HERITAC	BE HALL BLACKSTO	NE		900 S MAIN ST BLACKSTONE, VA 23824				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIAT			
F 695	On 3/05/19 at 9:50 Resident# 90's roor sitting in a chair next the nebulizer machine and the nebulizer machine of the nebulizer was on top off the nebulizer was on top off the nebulizer was on the nebulizer nurse) # 1. When a be stored when not should be kept in a name and the date were changed, this on Sundays." When cover the nebulizer used it, LPN # 1 stamask clean and free the nebulizer used it, LPN # 2 stamask clean and free the nebulizer used it, LPN # 3 stamask clean and free the nebulizer used it, LPN # 3 stamask clean and free the nebulizer used it, LPN # 3 stamask clean and free the nebulizer used it, LPN # 3 stamask clean and free the nebulizer used it, LPN # 3 stamask clean and free the nebulizer used it, LPN # 3 stamask clean and free the nebulize	a.m., an observation of m revealed Resident # 90 was at to her bed. Observation of the revealed it was on the bed hask was sitting on top of the uncovered.  B a.m., an observation of the m revealed the Resident # 90 her bed. Observation of the revealed the nebulizer mask rebulizer machine uncovered.  It with LPN (license practical asked a nebulizer mask should in use, LPN # 1 stated, "It plastic bag with the resident's when the mask and the tubing is done once a week usually a sked why it is important to mask after the resident has ted, "To keep the nebulizer of from germs."	F6					
7	References:							

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 03/19/2019 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

	CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLETED
		495353	B, WING		C 03/06/2019
	ROMDER OR SUPPLIER  E HALL BLACKSTONE	453333	STF	REET ADDRESS, CITY, STATE, ZIP CODE IS MAIN ST ACKSTONE, VA 23824	03/00/2019
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F 695	Continued From pag	ge 113	F 695		
F 697 SS=D	can lead to shortness was obtained from the https://www.nlm.nih  2. A chronic condition bronchi are thickens infection. People with periodic flare-ups of exacerbations. This from the website: https://www.lung.or.ng-disease-lookup///  3. High blood press obtained from the with https://www.nlm.nihessure.html  Pain Management CFR(s): 483.25(k)  §483.25(k) Pain Mathematical transfer with provided to resident consistent with provided to residents and the residents' this REQUIREMED by:  Based on staff interest and clinical record facility staff failed to consistent with propractice, for one of sample, Resident and staff for the sample, Resident and staff for the sample, Resident and staff for one of sample, Resident and staff for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample, Resident and staff failed to consistent with propractice, for one of sample and staff failed to consistent with propractice, for one of sample and staff failed to consistent with propractice, for one of sample and staff failed to consistent with propractice, for one of sample and staff failed to consistent with propractice, for one of sample and staff failed to consistent with propractice, for one of sample and staff failed to consistent with propractice a	gov/medlineplus/copd.html.  on where the walls of the ed from inflammation and ith bronchiectasis have for breathing difficulties, called a information was obtained g/lung-health-and-diseases/luporonchiectasis/  ure. This information was vebsite:  anagement.  sure that pain management is the who require such services, fessional standards of practice, person-centered care plan, goals and preferences.  Note that the properties of the service of the person-centered care plan, goals and preferences.  The surface of the service of the person of th	F 697	F697 Corrective Action(s): Resident #148's attending physician notified that the facility staff failed clarify the pain medication orders for resident #148 to indicate what type pain medication is to be administered based on pain scale score. A facility Incident and Accident form was completed for this incident.	to or of ed

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION (X3) DATE S COMPLI				
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		495353	B. WING		ž		06/2019	
NAME OF PI	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
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(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	E	(X5) COMPLETION	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		DATE	
F 697	Continued From page	- 11 <i>4</i>	F	697	Identification of Deficient			
	, -		1 '	00.	Practices/Corrective Action(s):			
		in medications to determine in medication should be			All other residents receiving pain	1	ı	
		dent #148 based on pain			medications may have been potentia	lly		
	parameters.	dent # 140 based on pain	. ]		affected. The DON, ADON, and/or			
	parameters.				Manager will conduct a 100% audit		l	
	The findings include:				resident's receiving PRN pain			
	The inusigs include.				medications to identify resident at ri			
	Resident #148 was a	dmitted to the facility on			inaccurate pain medication orders or	pain		
	!	mission on 1/24/19, with			medication orders that require	1		
	l .	led but were not limited to:			clarification. Residents identified at			
	1 -	pressure, chronic kidney			will be corrected at time of discover			
		n hemodialysis [a procedure	1		their comprehensive plans of care u	oatea		
		ons and renal [kidney] failure,			to reflect their resident specific need The attending physicians will be no			
	i .	impurities are removed from			of each negative finding and a facili			
	•	al machine (1)], COPD			Incident & Accident Form will be	ty .		
	1 -	onic, nonreversible lung			completed for each negative finding	<u>,                                     </u>		
	disease that is usual	ly a combination of			Completed for their integral of models	e.		
	emphysema and chr	onic bronchitis (2)], and			Systemic Change(s):			
	depression.				The facility policy and procedures h	ave		
					been reviewed and no revisions are			
		S (minimum data set)			warranted at this time. The nursing			
		care 30 day assessment,			assessment process as evidenced by			
		reference date of 2/21/19,			24-Hour Report and documentation			
	I .	s scoring a "15" on the BIMS			medical record /physician orders re			
,	3 '	ental status) score indicating			the source document for the develo			
	the resident was cap				and monitoring of the provision of			
	-	The resident was coded as			which includes, obtaining, transcrib and completing physician medication			
	, -	assistance of one or more			orders & treatment orders. The DO			
		of her activities of daily			and/or Regional nurse consultant w			
		Health Conditions, the			inservice all licensed nursing staff of			
		as having occasional pain			procedure for obtaining, transcribin			
		5" on a scale of 1 - 10, 10			completing physician medication a			
	being the worse patt	n they have ever been in.			treatment orders. As well as admin			
	The physician arda-	dated 1/34/10 decimented			the appropriate prn pain medication			
		dated, 1/24/19 documented, lenol) [used to treat mild pain			based on pain scale score.			
		MG (milligrams) Tablet, give					-	
		(by mouth) q (every) 4 hours						
		pain/fever >(greater than)					1	
ī	1 Ever (00 1100000) 101		1		1		1	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI		CONSTRUCTION	COM	SURVEY PLETED
		495353	B. WING			1	C /06/2019
	ROVIDER OR SUPPLIER			900	REET ADDRESS, CITY, STATE, ZIP CODE B S MAIN ST LACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(XS) COMPLETION DATE
F 697	101." A second phys documented, "Norco moderate to severe ptake 1/2 tab po q4ho  The January 2019 Madministration record medication orders. Tadministration of the following dates, time 1/17/19 at 1:23 a.m. 1/19/19 at 7:54 p.m. 1/22/19 at 4:53 p.m. 1/29/19 at 8:11 p.m. 1/30/19 at 10:53 a.m  The January 2019 Maddinistration of the dates, times with pai 1/1/19 at 5:26 p.m. f 1/2/19 at 6:13 p.m. f 1/3/19 at 5:33 p.m. f 1/3/19 at 5:33 p.m. f 1/1/19 at 5:50 a.m. 1/26/19 at 8:39 p.m. 1/25/19 at 8:28 a.m. 1/25/19 at 8:33 a.m. 1/26/19 at 6:03 p.m.	ician order dated 1/24/19 5-325 Tablet [used to treat pain (4)] - Norco 5/325 mg urs prn for pain."  AR (medication d) documented the above the MAR documented the Acetaminophen on the s, with pain levels as follows: for a pain level of 7 for a pain level of 4 to for a pain level of 5 to a pain level of 5 for a pain level of 6 for a pain level of 5 for a pain level of 6 for a pain level of 5 for a pain level of 6 for a pain lev	F	697	Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perweekly chart audits coinciding with care plan calendar to monitor for compliance. Any/all negative finding or errors will be corrected at time of discovery and disciplinary action wittaken as needed. Aggregate finding these audits will be reported to the Quality Assurance Committee quarfor review, analysis, and recommendations for change in fact policy, procedure, and/or practice. Completion Date: April 17, 2019	the  gs and  ll be s of  terly	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		N 	(X3) DATE SURVEY COMPLETED	
		495353	B. WING				C <b>/06/2019</b>
	PROVIDER OR SUPPLIER  GE HALL BLACKSTOI	NE		STREET ADDRESS, 900 S MAIN ST BLACKSTONE,	, CITY, STATE, ZIP CODE	, 00	100/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CC	DER'S PLAN OF CORRECTIO DRRECTIVE ACTION SHOULD FERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 697	administration recommedication orders. administration of the following dates, time 2/1/19 at 8:05 a.m. 2/5/19 at 8:24 a.m. 2/5/19 at 11:43 a.m. 2/8/19 at 5:17 a.m. 2/21/19 at 9:51 a.m. 2/22/19 at 7:53 a.m. 2/23/19 at 9:42 a.m. 2/25/19 at 1:12 a.m. 2/26/19 at 9:01 a.m. The February 2019 medication orders. administration of the dates, times with pa 2/1/19 at 5:00 a.m. 12/1/19 at 6:26 p.m. 12/2/19 at 11:55 p.m. 2/3/19 at 10:01 p.m. 2/4/19 at 6:21 p.m. 12/5/19 at 11:38 p.m. 2/6/19 at 11:38 p.m. 2/6/19 at 11:39 p.m. 2/6/19 at 11:53 p.m. 2/9/19 at 11:53 p.m. 2/9/19 at 11:53 p.m. 2/9/19 at 11:53 p.m. 2/10/19 at 8:51 a.m. 2/10/19 at 10:34 p.m.	rd) documented the above The MAR documented the expectaminophen on the expectaminophen of 5 for a pain level of 7 for a pain level of 3 for a pain level of 3 for a pain level of 4 for a pain level of 5 for a pain level of 6 for a pain level of 6 for a pain level of 9 for a pain level of 8 for a pain level of 5	F 6	97			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	405252				С	
NAME OF BROWNERS OF SURELY	495353	B. WING _			/06/2019	
NAME OF PROVIDER OR SUPPLIES HERITAGE HALL BLACKSTO	ONE		STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824	DDE		
PREFIX (EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
The March 2019 Medication oders. administration of the administered on 3 level not document.  The March 2019 Medication orders administration of the dates, times with process administration of 1/31/19 at 12:41 a.m. 3/1/19 at 12:41 a.m. 3/3/19 at 12:09 a.m. 3/6/19 at 9:36 a.m.  The comprehensive on 1/31/19, documented, "Process or decended. Assess document and represented and represented and the process of the dates	.m. for a pain level of 4 m. for a pain level of 10.  MAR documented the above The MAR documented the he Acetaminophen was /3/19 at 6:08 a.m. for a pain	F 69	97			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495353	B. WING		03	C 03/06/2019	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL BLACKSTONE			STREET ADDRESS, CITY, STATE, ZIP CO 900 S MAIN ST BLACKSTONE, VA 23824		700/2019		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 697	resident she is alert for a specific medic have seen orders the pain from 1-4 you get and if the pain is 5-them the stronger medications as their pain was 1-4."  An interview was conurse) #3, the unit ma.m. RN #3 was asked how the medication to give, I clarification of those to be added to the output of the pain was asked how the medications as the facility policy, "A Medications" documpain medications as According to "Lippin Practice", Eighth Ed Wilkins, pg. 87 read dosages or unfamilia confirmed with the helpharmacist before a following is documer Orders: 2. Although follow an order you to just ignore a medication, him, obtain appropria	and oriented and does ask ations." LPN #1 stated, "I nat tell the nurse if they have ive, normally, some Tylenol, 10 on a pain scale you give nedication." When asked if aking the decision what to , "Yes, I would give them the ras from 5-10 and Tylenol if anducted with RN (registered nanager, on 3/6/19 at 11:50 and to review the above ications. Once reviewed, RN he nurses' know which RN #3 stated, "We need orders. The pain level needs orders."	F 69	97			

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  900 S MAIN ST	(X5)
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  900 S MAIN ST	(X5)
HERITAGE HALL BLACKSTONE  BLACKSTONE, VA 23824	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION DATE
F 697  Administrative staff member (ASM) #1, the administrative staff member of president of operations, were made aware of the above findings on 3/6/19 at approximately 6:00 p.m.  On 3/6/19 at 8:15 p.m. ASM #2, the director of nursing, was asked which professional standard of practice the facility follows, ASM #2 stated they follow their policies and Lippincott."  No further information was provided prior to exit.  (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 266.  (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.  (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.h tml  (4) This information was obtained from the following website: https://medlineplus.gov/ency/article/002670.htm Food Procurement, Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)  \$483.60(i) Food safety requirements. The facility must -  \$483.60(i) 1 - Procure food from sources approved or considered satisfactory by federal, state or local authorities.  (i) This may include food items obtained directly from local producers, subject to applicable State	

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL BLACKSTONE  STREET ADDRESS, CITY, STATE, ZIP CODE  900 S MAIN ST  BLACKSTONE, VA 23824  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DATE  OUT OF THE PROVIDER OF THE PROPERTY OF THE PROPERTY OF THE PROPRIATE DATE  DATE  OUT OF THE PROVIDER OF THE PROPERTY							С	
HERITAGE HALL BLACKSTONE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) COMPLETIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)			495353	B. WING_			03/	06/2019
HERITAGE HALL BLACKSTONE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  (X5) COMPLETIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  (X6) DEFICIENCY	NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  BLACKSTONE, VA 23824  (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COMPLETED TO THE APPROPRIATE DEFICIENCY)  DEFICIENCY)	HERITAGI	FHALL REACKSTONE			900	S MAIN ST		
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LINEE BENOROTORE			BLA	ACKSTONE, VA 23824		
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	(X5) COMPLETION DATE
F 812 and local laws or regulations.  (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.  (iii) This provision does not preclude residents from consuming foods not procured by the facility.  § 483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.  This REGUIREMENT is not met as evidenced by:  Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in a sanitary manner in the facility's kitchen.  The facility staff failed to ensure an opened five-pound container of pimento spread available for use had an open date and a use-by-date.  The findings include:  On 03/04/19 at 6:30 p.m., an observation of the single door reach-in refrigerator revealed a law see-by-date. Further observation of the single door reach-in refrigerator revealed a law see-by-date. Further observation of the container reviewed and unreadable. After looking at the black stampe and examining the container of "Pimento Spread" OSM # 1 stated, "I can't read the use-by-date. When asked if there	F 812	and local laws or regi (ii) This provision doe facilities from using p gardens, subject to c safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food set This REQUIREMENT by:  Based on observation document review it w failed to store food in facility's kitchen.  The facility staff failed five-pound container for use had an open The findings include:  On 03/04/19 at 6:30 facility's kitchen was staff member) # 1, co single door reach-in five-pound container approximately two-the for use. Observation container failed to evuse-by-date. Further revealed a black star container. Observatire revealed it was blurrelooking at the black scontainer of "Piment"	ulations. es not prohibit or prevent produce grown in facility compliance with applicable d-handling practices. es not preclude residents is not procured by the facility.  prepare, distribute and ance with professional envice safety.  This not met as evidenced on, staff interview, and facility as determined facility staff as a sanitary manner in the  dieto ensure an opened of pimento spread available date and a use-by-date.  p.m., an observation of the conducted with OSM (other book. An observation of the refrigerator revealed a of "Pimento Spread" with wides remaining and available of the "Pimento Spread" widence an open date and a reposervation of the container mped date on the side of the ion of the black stamp ed and unreadable. After estamp and examining the of Spread" OSM # 1 stated, "I	F8	112	Corrective Action(s): All other food items in the kitchen have been potentially affected. The Service Manager will inspect the k dry storage areas, the walk-in freez reach in freezers and refrigerators identify any negative findings. All negative findings will be corrected of discovery and appropriate discipaction taken as needed. A facility Incident and Accident form will be completed for each negative finding identified.  Systemic Change(s): Current facility policy & procedure been reviewed and no changes are warranted at this time. The Dietary manager will inservice the dietary the proper preparing, storing and distribution of food under sanitary conditions, as well as the policy for proper food storage to include prolabeling and dating.  Monitoring: The Dietary Manager is responsibe maintaining compliance. The Administrator and/or Food service manager will complete the Kitchet tool weekly for monitoring and maintaining compliance. The rest these audits will be reported to the Quality Assurance Committee for analysis, & recommendations for in facility policy, procedure, and/or practice.	may e Food citchen zer, to l at time plinary e ag e has y staff on or per le for e n audit alts of review, change	

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495353	B. WING			C 03/06/2019	
NAME OF PR	ROVIDER OR SUPPLIER	10000		s	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/0	012019
	THE DE LOCATION			90	OS MAIN ST		
HERITAGE	HALL BLACKSTONE			В	LACKSTONE, VA 23824		
(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 B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
F 842 SS=D	# 1 stated, "No." Whe procedure for storing kitchen, OSM # 1 state when it was opened at when a food is no lor should be discarded. Component of proper identify foods, especification storagemust be covered, labelabel. All food should be assured that the for discarded by the understand the form of the proper identify foods assured that the form of the proper identification of the properties of the proper identification of the properties of t	en asked to describe the open food items in the ted, "It should be dated and a use-by-date."  Covering, Labeling, Dating Good storage guidelines food correctly to determine oger safe to consume and Food labeling is also a food storage to easily itelially when the food has been ginal packaging." Under e" it documented, "All foods teled and dated with a date of the monitored each day to coods will be used, consumed the ember of the findings.  The same of the findings.  In was provided prior to exit. Itelially the public. The information is to the public. The same open formation that is to the public.		812	F842 Corrective Action(s): Resident #9's attending physician he been notified that the facility staff fat to document the non-pharmacologic interventions attempted prior to the administration of a PRN pain medic A facility incident and accident for been completed for this incident.	ailed cal cation.	
	10 00 00.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
	495353	B. WING		HALLIMOTE TO THE STATE OF THE S		, )6/2019
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL BLACKSTONE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		ID.	90	REET ADDRESS, CITY, STATE, ZIP CODE  0 S MAIN ST  ACKSTONE, VA 23824  PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX (EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	x	(EACH CORRECTIVE ACTION SHOULD ! CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
professional standard must maintain medic that are- (i) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The fact all information contain regardless of the formation records, except where (ii) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pactive operations, as permit with 45 CFR 164.50 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research medical examiners, a serious threat to he by and in compliance §483.70(i)(3) The factive for- (ii) The period of times.	ecords. rdance with accepted ds and practices, the facility al records on each resident  mented; le; and rganized  cility must keep confidential ined in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law; is ayment, or health care itted by and in compliance	F	842	Identification of Deficient Practice Corrective Action(s):  All other residents may have potentibeen affected. A 100% review of all residents receiving routine or PRN p medication orders and MAR's, will conducted by the DON and/or Unit Manager to identify residents at risk inappropriate documentation of non pharmacological interventions. All negative findings will be clarified at correct at time of discovery. A facil Incident & Accident form will be completed for each negative finding.  Systemic Change(s):  The facility policy and procedure her been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant clinical documentation standards pfacility policy and procedure. This inservice will include the standards proper documentation for intervention both pharmacological and non-pharmacological implemented whe administering routine or PRN pain medications.	aily ain be for ad/or ity as the on the er s for tions	

PRINTED: 03/19/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
					•	С	
		495353	B. WING			03/0	6/2019
	ROVIDER OR SUPPLIER E HALL BLACKSTONE			900	REET ADDRESS, CITY, STATE, ZIP CODE DIS MAINIST ACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The me (i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review of determinations condu (v) Physician's, nurse professional's progre (vi) Laboratory, radio services reports as re This REQUIREMEN' by: Based on staff intervand clinical record re the facility staff failed accurate clinical record the survey sample, F  The facility staff failed non-pharmacologica provided for Residen administering as need dates in February 20  The findings include:  Resident #138 was a 9/1.4/16. Resident # were not limited to h B12 deficiency and of most recent MDS (m significant change in	and in State law; or are after a resident reaches a law.  Idical record must containtion to identify the resident; sident's assessments; we plan of care and services by preadmission screening evaluations and acted by the State; b's, and other licensed as notes; and logy and other diagnostic equired under §483.50.  To is not met as evidenced between the worker was determined that the maintain a complete and and for one of 51 residents in Resident #138.  If the document that were at #138 in addition to be ded Tylenol (1) on multiple in the constipation. Resident #138's	F	342	Monitoring: The DON is responsible for maintain compliance. The DON and/or design will audit medical records weekly coinciding with the care plan calenda monitor for compliance. Any/all negatindings will be clarified and correcte time of discovery and disciplinary act will be taken as needed. The results of this audit will be provided to the Qua Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice.  Completion Date: April 17, 2019	ee r to ative d at tion of dity	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		B. WING	B. WING			C 03/06/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE			STREET ADDRESS, CITY, STATE, 2 900 S MAIN ST BLACKSTONE, VA 23824	ZIP CODE	1 03/	00/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 842	impaired. Section of having received PR medication and non during the last five of Resident #138 reported and the last five of Resident #138 reported and the last five of Review of Resident revealed a physician Tylenol 650 mg (mill (as needed) for pair Review of Resident (medication administresident was administresident was administresident #138's MA notes failed to reveat Resident #138 was interventions prior to administration of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation of PF dates. Review of Recomprehensive care reveal documentation administration of PF dates. Review of Recomprehensive care reveal documentation dates	s cognition as severely coded Resident #138 as N (as needed) pain redication intervention days. Section J further coded red having frequent pain days.  #138's clinical record n's order dated 1/29/19, for ligrams) every six hours PRN or a fever greater than 101. #138's February 2019 MAR stration record) revealed the istered PRN Tylenol on 9, 2/10/19, 2/11/19, 2/12/19, d 2/18/19. Further review of JR, MAR notes and nurses' all documentation that offered non-pharmacological or in addition to the RN Tylenol on all the above esident #138's plan dated 2/15/19 failed to	F8	42			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495353	B. WING			C
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	03/06/2019
HERITA	GE HALL BLACKSTO	NE		900 S MAIN ST BLACKSTONE, VA 23824		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	
F 842	documented each ti stated, "You should stated, "Just to show a pill; that you tried discomfort." LPN # repositioning to Resadministered PRN she documented thi intervention, LPN #8 say where she docusome residents' MA containing a list whe provided non-pharm #5 stated she though ya certain way the computer system. A recall if Resident #1 LPN #5 stated she wof Resident #138's floption.  On 3/6/19 at 4:50 p. member) #1 (the ad regional nurse consregional vice presidered.	When asked if all interventions should be ime they are offered, LPN #5." When asked why, LPN #5. what you didn't just give them something else to relieve their 5 stated she provided sident #138 each time she fylenol. When asked where is non-pharmacological 5 stated she really could not amented this information but the first have a drop down box ere nurses can select the nacological intervention. LPN ht this process was generated to orders are put into the When asked if she could 38's MAR had this option, was not sure. Further review MAR failed to reveal this  m., ASM (administrative staff ministrator), ASM #3 (the ultant) and ASM #4 (the ent of operations) was made	F 84	42		
	administration docur document the effect non-pharmacologica	garding pain medication mented, "5. Evaluate and iveness of al interventions"				
- Bernerson Actions	information was obta	ained from the website: gov/druginfo/meds/a681004.h				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495353	B. WING	•	C 03/06/2019	
	ROVIDER OR SUPPLIER E HALL BLACKSTONE			STREET ADDRESS, CITY, STATE, ZIP CODE 900 S MAIN ST BLACKSTONE, VA 23824		
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 842	Continued From page	e 126	F 84	42		
F 880 SS=D	Infection Prevention of CFR(s): 483.80(a)(1)  §483.80 Infection Con The facility must estainfection prevention a designed to provide a comfortable environmed evelopment and tradiseases and infection program.  The facility must estain and control program a minimum, the following services and communicable of staff, volunteers, visit providing services and accepted national staff. §483.80(a)(1) A system of surversible communication of the pout are not limited to (i) A system of surversible communication.	(2)(4)(e)(f)  Introl  Iblish and maintain an and control program  Is safe, sanitary and ment and to help prevent the insmission of communicable ins.  Interpolation and control  Iblish an infection prevention (IPCP) that must include, at wing elements:  Interpolation and controlling infections liseases for all residents, tors, and other individuals inder a contractual upon the facility assessment into §483.70(e) and following andards;  In standards, policies, and regram, which must include, it illiance designed to identify ible diseases or	F 88	Corrective Action(s):  C.N.A. #4 that was assisting resi #108 with their meal has been in on proper handwashing procedur followed when assisting other re while in the dining room assistin residents with their meals. A fact Incident & Accident form was conforthis incident.  Identification of Deficient Practice Action(s): All residents may have the poter affected by improper infection of techniques related to improper handwashing and feeding practice DON, ADON or designee will proper infection control practice the meal service and while feed residents. Any/all negative find be corrected at time of discover disciplinary action taken as nee facility Incident and Accident for each negative.  Systemic Change(s): The facility policy and procedure been reviewed and no changes warranted at this time. All facility will be inserviced on the facility will be inserviced on the facility.	serviced res to be sidents ag illity completed scrice(s) & sidents at the secontrol ces. The cerform 3 crve for es during ing ings will y and ded. A form will finding.	
	persons in the facilit (ii) When and to who communicable disea reported;	y can spread to other y; om possible incidents of use or infections should be unsmission-based precautions		and procedure for maintaining infection control practices. The training will include proper has and feeding procedures to be for during all meal services by the and/or Regional Nurse Consult	inservice ad washing bllowed DON	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE COMP	SURVEY LETED
		495353	B. WING			I	06/2019
	ROVIDER OR SUPPLIER E HALL BLACKSTONE			٤	STREET ADDRESS, CITY, STATE, ZIP CODE 300 S MAIN ST BLACKSTONE, VA 23824		
(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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	to be followed to prev (iv)When and how iso resident; including bu (A) The type and dura depending upon the i involved, and (B) A requirement that least restrictive possi circumstances. (V) The circumstance must prohibit employed disease or infected si contact with residents contact will transmit t (vi)The hand hygiene by staff involved in di §483.80(a)(4) A syste identified under the fa corrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection.  §483.80(f) Annual re The facility will condu IPCP and update the This REQUIREMEN' by: Based on observatio interview, facility doc record review, it was failed to maintain infe one of 51 residents in Residents #108.	rent spread of infections; plation should be used for a at not limited to: ation of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the sunder which the facility ees with a communicable kin lesions from direct sor their food, if direct he disease; and a procedures to be followed rect resident contact.  The for recording incidents acility's IPCP and the ten by the facility.  The store, process, and is to prevent the spread of the view.  The store is not met as evidenced on, resident interview, staff ument review and clinical determined the facility staff ection control practices for	F	880	Monitoring:  The DON will be responsible for monitoring compliance. The DON, ADON, and/or designee will perfort random weekly Dining room adutis during meal times to monitor for preinfection control practices and hand washing during resident mela times while assisting with feeding resident maintain compliance. Any/all negate findings will be corrected at time of discovery and one-on-one inservice training will be completed with staff member. Detailed findings of the at will be reported to the Quality Assu Committee for review, analysis and recommendations for change in fact policy, procedure, and/or practice.  Completion Date: April 17, 2019	and t to ive f ndits	

STATEMENT AND PLAN (	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495353	B. WING			l	C <b>06/2019</b>
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL BLACKSTONE			900	REET ADDRESS, CITY, STATE, ZIP CODE OS MAIN ST ACKSTONE, VA 23824	03/	00/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	***************************************	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880		<del>-</del>	F 8	80			
		g other residents in the n and returning to feed		***************************************			
	The findings include	e:		THE RESIDENCE AND THE PERSON NAMED IN STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET, STREET,			**************************************
	8/1/16 with the diagroup by blood pressure depression with psy metabolic encephalmeter encephalmet	admitted to the facility on noses of but not limited to hrenia, Alzheimer's disease, s, sleep apnea, osteoporosis, ochotic symptoms, and opathy. Resident #108's most um data set) was a quarterly ARD (assessment reference ne resident was coded as tance for all areas of activities					
or an annual section of the section	p.m., observations v	imately 1:30 p.m. to 1:50 vere made in the Cottage unch meal. The following					
-	On 3/5/19 at approx (Certified Nursing As the table feeding Re	imately 1:30 p.m., CNA #4 ssistant) was sitting down at sident #108.				Ментендентина	
1,000	feeding Resident #1 another resident who and touched the per resident. CNA #4 th	imately 1:33 p.m., while 08, CNA #4 got up to assist o was leaving the dining room sonal wheelchair of another en returned to the table to without washing or sanitizing				AND AND THE PARTY OF THE PARTY	
- Annahanan	was observed stand # 108, to speak with	imately 1:35 p.m., CNA #4 ing up from feeding Resident another resident and was resident on the back as the		60mmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmmm			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
<b>495353</b> B. WING	C 03/06/2019
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL BLACKSTONE  STREET ADDRESS, CITY, ST.  900 S MAIN ST  BLACKSTONE, VA 238	ATE, ZIP CODE
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE COMPLETION DATE ICIENCY)
F 880  Continued From page 129 resident was leaving the dining room. CNA #4 then returned to the table to feed Resident #108 without washing or sanitizing her hands.  On 3/5/19 at approximately 1:44 p.m., CNA #4 was observed standing up from feeding Resident #108, to help another resident place her tray onto the tray cart. CNA #4 then returned to the table to feed Resident #108 without washing or sanitizing her hands.  On 3/5/19 at approximately 1:45 p.m., CNA #4 was observed reaching across the table to assist another resident with his tray. CNA #4 then returned to feeding Resident #108 without washing or sanitizing her hands.  On 3/05/19 at 3:44 p.m., in an interview with CNA #4, when asked what protocols the facility follows to maintain infection control in the dining room, CNA #4 stated, "I should wash or sanitize my hands when I do other things before returning to feed a resident." When asked about the observations of assisting multiple residents back and forth and not washing or sanitizing her hands between them, CNA #4 stated, "We do not have any sanitizers in the dining room, just the wipes (which were kept in a locked cabinet). I should have washed or sanitized my hands before feeding a resident again."  A review of the facility policy, "Handwashing/Hand Hygiene" documented, "All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to otherresidents Use an alcohol-based hand rub containing at least 62% alcohol; or alternatively, soap (antimicrobial or non-antimicrobial) and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495353	B. WING		C 02/05/0010		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BLACKSTONE				03/06/2019			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 880	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 8	80			