State of Virginia (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: ___ B. WING 04/25/2019 VA0105 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 16600 DANVILLE PIKE **HERITAGE HALL - LAUREL MEADOWS** LAUREL FORK, VA 24352 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 000 F 000 Initial Comments F 001 Director of Nursing An unannounced Medicare/Medicaid standard 12 VAC 5-371-200 (B) (1), Cross survey and biennial State Licensure Inspection References to F Tag 658 was conducted 4/23/19 through 4/25/19. One Cross Reference POC for F Tag 658 complaint was investigated during the survey. Corrections are required for compliance with 42 Nursing Services CFR Part 483 Federal Long Term Care 12 VAC 5-371-220 (H) - Cross Reference to requirements and Virginia Rules and Regulations F Tag 580 for the Licensure of Nursing Facilities. The Life Cross Reference POC for F Tag 580 Safety Code survey/report will follow. 12 VAC 5-371-220 (A, B, D) - Cross The census in this 60 certified bed facility was 58 Reference to F Tag 684 at the time of the survey. The survey sample Cross Reference POC for F Tag 684 consisted of 15 current Resident reviews and 3 12 VAC 5-371-220 (C) (3) and (G) - Cross closed record reviews. Reference to F Tag 690 Cross Reference POC for F Tag 690 F 001 F 001 Non Compliance **Dietary Services** The facility was out of compliance with the 12 VAC 5-371-340 (A) - Cross Reference to following state licensure requirements: F Tag 812 Cross Reference POC for F Tag 812 This RULE: is not met as evidenced by: The facility was not in compliance with the Pharmaceutical Services following Virginia Rules and Regulations for the 12 VAC 371-300 (H) - Cross Reference to F Tag 756 Licensure of Nursing Facilities: Cross Reference POC for F Tag 756 Director of Nursing 12 VAC 371-300 (H) - Cross Reference to F 12 VAC 5-371-200 (B) (1), cross reference to F Tag 758 Tag 658 Cross Reference POC for F Tag758 **Nursing Services** Clinical Records 12 VAC 5-371-220 (H) cross reference to F Tag 12 VAC 371-360 (A) (E) (7) - Cross Reference to F Tag 842 12 VAC 5-371-220 (A, B, D) cross reference to F Cross Reference POC for F Tag 842 Tag 684 12 VAC 5-371-220 (C) (3) and (G) cross Completion Date: June 7, 2019 reference to F tag 590 **Dietary Services** 12 VAC 5-371-340 (A,) cross reference to F tag

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

Wrightly Darnell

Odministrator

(X6) DATE

If continuation sheet 1 of 2

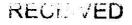
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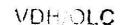
FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: _ B. WING_ VA0105 04/25/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE **HERITAGE HALL - LAUREL MEADOWS** LAUREL FORK, VA 24352 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 001 F 001 Continued From page 1 812 Pharmaceutical services. 12 VAC 5-371-300 (H) cross reference to F tag 12 VAC 5-371-300 (H) cross reference to F tag 758 Clinical Records 12 VAC 5-371-360 (A) (E) (7) cross reference to F Tag 842

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If continuation sheet 2 of 2





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| TATEMENT D | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIENCLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A BUILDING B WING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C 04/25/2019 |
|--------------------------|---|---|---------------------------------|---|--|
| | OVIDER OR SUPPLIER | POUND | 1000 | TREET ADORESS, CITY, STATE, ZIP CODE 8600 DANVILLE PIKE | 2 |
| HERITAGE | HALL - LAUREL MEA | ibows | L | AUREL FORK, VA 24362 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE) | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE COMPLETION |
| E 000 | Initial Comments | | E 000 | | 9 |
| F 000 | survey was conduct 04/25/19. The facility compliance with 42 Requirement for Lo | ing-Term Care Facilities. One stigated during the survey. | F 000 | * | |
| r | Survey was conduct One complaint was survey. Correction | | | | |
| F 580 SS=D | at the time of the s consisted of 15 cur closed record revie Notify of Changes | (Injury/Decline/Room, etc.) | F 580 | Resident #53's attending physician in been notified that facility staff failed | as to |
| | (i) A facility must in consult with the reconsult with the reconsistent with his representative(s) v (A) An accident invesults in injury and physician intervent (B) A significant channels, or psychos | rolving the resident which It has the potential for requiring tion; ange in the resident's physical, social status (that is, a | | notify the attending physician that resident #53 refused their physician ordered Victoza insulin on 4/5 & 4/9 A Facility Incident & Accident form been completed for this incident. Resident #25's attending physician the been notified that facility staff failed notify the attending physician that resident #25 refused their sliding sea Novolog insulin coverage on 3/12, 3/15, 3/16, 3/17, 3/19, 3/20, 3/21/19 | has to the |
| 1 | status in either life- clinical complication (C) A need to alter | alth, mental, or psychosocial threatening conditions or ins); treatment significantly (that is, excepted REPRESENTATIVES SIGNATURES SIGNATURES SIGNATURES | | Pacility Incident & Accident form be been completed for this incident. | RS (KS) DATE |

Any deficiency statement ending with an esterisk (*) denotes a deficiency which the inabbuton may be excused from correcting providing it is determined that other safeguerds provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are discosable 80 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are clied, an approved plan of correction is requisite to continued program participation.

Feelfity ID: VA0105

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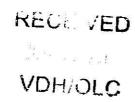
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 0.000 | IPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|---|--|--|
| | | | | 7990) | c | |
| | | 495323 | B. WING_ | | 04/25/2019 | |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAD | ows | | STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPROFICE (CORRECTIVE) | D BE COMPLETION | |
| F 580 | a need to discontinue treatment due to adve commence a new form (D) A decision to transesident from the faci §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent informatic is available and proving physician. (iii) The facility must a resident and the section (iv) The facility must rupdate the address (ruphone number of the representative(s). §483.10(g)(15) Admission to a composite dis §483.5) must disclose its physical configurationations that comprising part, and must specify room changes between under §483.15(c)(9). This REQUIREMENT by: Based on staff intervitant dinical record revitant dinical record revitant and clinical record revitant and clinical record revitant and record re | an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the lent representative, if any, or roommate assignment 10(e)(6); or ent rights under Federal or ns as specified in paragraph ecord and periodically mailing and email) and | F | Identification of Deficient Practic & Corrective Action(s): All other residents receiving physic ordered insulin and physician order sliding scale insulin coverage may be potentially been affected. The DON Unit Manager will conduct a 100% review of all MAR's for residents receiving physician ordered insulin sliding scale insulin for the last 30 identify residents that had refused to physician ordered insulins or sliding insulins with no physician notificat. An incident & accident form will be completed for all negative findings will be corrected at time of discovers. Systemic Change(s): The facility policy and procedures been reviewed and no changes are warranted at this time. The 24 Hour Report and documentation in the more record will serve as the source doctor communicating changes in resist condition/status, refusal of medical and treatment and proper notification responsible parties and physicians. Licensed staff will be inserviced by DON and/or Regional nurse consult the Notification of Rights & Service issued a copy of company policy a procedure. The inservice will inclusting the party when changes or refusals of treatment, medications condition occur in order to prevent delay of services while promoting continuity of care. | ian ed nave and and days to heir g scale ion. e and ry. have r nedical ument dent care on to y the ltant on ces and nd ude f cian and or t a | |

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

Event ID: XQ8811

Facility ID: VA0105

If continuation sheet Page 2 of 30



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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A CARLO CARGO AD SECURIO DE | PLE CONSTRUCTION G | (X3) DA | TE SURVEY MPLETED |
| 3. 2 | | 495323 | B. WING | <u> </u> | | C 94/25/2019 |
| NAME OF P | ROVIDER OR SUPPLIER | · · · · · · · · · · · · · · · · · · · | | STREET ADDRESS, CITY, STATE, ZIP CODE | <u> </u> | 4123,2013 |
| HERITAG | E HALL - LAUREL MEAD | oows | | 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 580 | nurse for 2 of 18 resident #25). The findings included 1. The facility staff fawhen Resident #53 retwo dates (4/5/19 and on 4/5/19 and 4/9/19. Physician was informed 4/5/19 and 4/9/19. Resident #53 was addend readmitted 1/16/1 included but not limited with diabetic neuroparsclerosis, hyperlipider age related osteoporolidiopathic scollosis, pedepressive disorder, opulmonary disease, a sacrum. Resident #53's quarted (MDS) assessment with reference date (ARD) resident with a BIMS (status) Summary Scolings or symptoms of affecting others. Residelusions. Problem for planned with onset date. | iled to notify the physician efused insulin (Victoza) on a 4/9/19). Victoza was held There was no evidence the ed of the insulin held on mitted to the facility 5/21/07 19 with diagnoses that ed to type 2 diabetes mellitus thy, sepsis, multiple mia, hypertension, anemia, biss, chronic kidney disease, aranoid schizophrenia, chronic obstructive and pressure ulcer of 1/9/19 assessed the first interview for mental re as 15/15. There were no delirium or behaviors dent #53 did exhibit or nutrition was care te of 4/10/19. Resident #53 | F 58 | | mplete g with the for findings scovery. udits will be for review, for changes nd/or | |
| | mellitus. Approaches: (medications) per MD The April 2019 physici | ycemia type 2 diabetes | | | | |

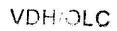
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VA0105

If continuation sheet Page 3 of 30

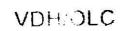




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| STATEMENT OF DEFICIENCIES (X: AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER. | (X2) MULTIPLE CO A. BUILDING | NSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
|---|--|---|---------------------------------|--|---------------------------|-------------------------------|--|
| | | 495323 | B. WNG | | C | 040 | |
| NAME OF PE | ROVIDER OR SUPPLIER | 1 70020 | | ET ADDRESS, CITY, STATE, ZIP COD | 04/25/20 | J1 9 | |
| | | | | 0 DANVILLE PIKE | | | |
| HERITAGE | HALL - LAUREL MEA | ADOWS | 1000 0000 | REL FORK, VA 24352 | | | |
| 1 | | | LAU | NEL FORK, VA 24352 | <u></u> | | |
| (X4) ID | | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL | ID | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION | | (X5) IPLETION | |
| PREFIX TAG | | R LSC IDENTIFYING INFORMATION) | PREFIX TAG | CROSS-REFERENCED TO THE DEFICIENCY) | | DATE | |
| | | | | 3,000 Part 1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (1 (| | | |
| F 580 | Continued From pa | ge 3 | F 580 | | | | |
| | pen Inj (inject) 1.8 r | ng (milligrams) subq | ь | | | | |
| | (subcutaneously) d | aily DM (diabetes mellitus)." | | | | | |
| | The surveyor review | wed the April medication | 8 " | | | | |
| | | rd (eMAR). There were "N"s | E s | | | | |
| | | /19, 4/5/19, 4/7/19 and 4/9/19. | Į. | | 1 | | |
| | | f. The surveyor reviewed the | G | | | | |
| | | the eMAR. Resident #53 had | | | | | |
| | refused the insulin | Victoza on 4/1/19 and 4/5/19; | | | | | |
| | | sponsible party) and MD had | | | i | | |
| | | sident #53 also refused the | * | | | | |
| 1 | | /5/19 and 4/9/19. The | | | | | |
| 1 | | 4/5/19 read "Inj 1.8 scheduled | | | | | |
| 8 | | m. was held" and the | | | | | |
| 3 | | 4/9/19 read "Inj 1.8 scheduled | | | | | |
| | for 4/9/19 7:30a.m. | | | | | | |
| | A STATE OF THE PROPERTY OF THE | wed the departmental noted | | | | | |
| | | 2 a.m., 8:45 a.m., 2:28 p.m., | | | | | |
| | i on the second second | re was no documentation the | | | | | |
| | | e aware the resident had | 36 | | | | |
| ł | refused the insulin a | and the surveyor was unable | Ĭ. | | | | |
| | | n order to hold the Victoza | | | | | |
| | insulin on 4/5/19 an | d 4/9/19. The departmental | 15 | | | | |
| | notes for 4/9/19 tim | ed at 12:52 a.m., 9:36 a.m., | II. | | | | |
| ľ | 1:52 p.m., 2:30p.m. | , 4:38 p.m., and 11:52 p.m. | | | | | |
| | did not have docum | entation the physician was | 155 155 | | | | |
| | informed that Victor | za had been held. The timed | | | X | | |
|] | note of 7:44 a.m. di | d document the Victoza had | | | | | |
| i | been held but no do | ocumentation that the | 1 | | | | |
| | physician had been | informed., | | | | | |
| | The surveyor inform | ned the interim director of | | | 5 | | |
| Ī | | e concern on 4/25/19 11:42 | i ' | | î | | |
| | 177 | the facility policy on | ** ** | | | | |
| | | of condition, diabetes mellitus, | Œ | | | | |
| | 5.00 | ers. The interim DON stated | | | | | |
| | | ne nursing staff to inform the | | | Y | | |
| | | dications were refused x2. | | | | | |
| | priyalcian when mei | ulcations were refused xz. | | | 1 | | |
| M CMS-2567 | 7(02-99) Previous Versions 0 | Dissolete Event ID, XQ88 | 311 Facilet | ID VA0105 | If continuation sheet Pag | - A c' | |

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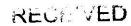
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 10 100 to 00 | IPLE CONSTRUCTION | (X | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|---|-----------|-------------------------------|--|
| | | 495323 | B. WING_ | | | C 04/25/2019 | |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAD | 16600 DANVILLE PIKE | | E | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR ([EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 580 | The facility policy title Condition or Status" r notify the resident's A physician on call whe need to alter the resident significantly and f. ref medications two (2) or The facility policy title Treatment Orders" reshall be administered of a person duly licen prescribe such medications the surveyor informed interim director of nurcoordinator and the content above concern on No further information exit conference on 4/2 2. The facility staff fawhen Resident #25 ref (Novolog). The clinical record of 4/23/19 through 4/25/admitted to the facility 3/11/19 with diagnosis limited to type 2 diabeted. | d "Change in a Resident's ead in part "1 The nurse will ttending Physician or in there has been a (an) e. Itent's medical treatment usal of treatment or in more consecutive times." d "Medication and ad in part "1. Medications only upon the written order sed and authorized to ations in this state." d the administrator, the sing, the minimum data set orporate registered nurse of 4/25/19 at 12:51 p.m. was provided prior to the 25/19. Ited to inform the physician fused sliding scale insulin Resident #25 was reviewed 19. Resident #25 was 11/28/15 and readmitted is that included but not tes mellitus, fracture of right rial fibrillation, edema, | F5 | 580 | | | |
| 1 | obstructive pulmonary kidney disease (stage Resident #25's admis (MDS) assessment wi | disease, and chronic III). sion minimum data set | | | | | |

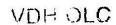
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID VA0105

If continuation sheet Page 5 of 30





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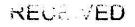
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 20 0000 10 | IPLE CONSTRUCTION | (X: | 3) DATE SURVEY COMPLETED |
|--------------------------|---|--|---------------------|---|--------------------------------|-----------------------------|
| | | 495323 | B. WING_ | | | C 04/25/2019 |
| | ROVIDER OR SUPPLIER | oows | | STREET ADDRESS, CITY, STATE, ZIP CO 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | ODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | 1D PREFI) TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5; COMPLETION DATE |
| F 580 | status) as 15/15. Re symptoms of delirium affecting others. Resident #25's currer was reviewed. The p date of 3/20/19 identifor hypo/hyperglycem Approaches: Adminim MD (medical doctor) The March 2019 phys "Novolog 100 units/m (sliding scale insulin) (before meals and at 150-200=3 units 201-250=5 units 251-300=7 units 301-350=9 units 351-400=11 units, > (greater than) 400= 100 greater than 500 on 200 The March 2019 elections of the symptoms | (brief interview for mental sident #25 had no signs or in psychosis, or behaviors of the comprehensive care plan problem nutrition with onset fied the resident to be at risk his due to type 2 diabetes. Ster meds (medications) per order. Sician's orders read in part of (milliliter) flexpen SSI with accuchecks AC/HS bedtime) =13 units less than 60 or expectation of the cocasions 6 hours apart." tronic medication of (eMARs) were reviewed the had "N" in the was 171 was 161. was 223 was 201 35 was not of a not available. was 180 35 was 219 35 was 262 was 193 | F | | | |

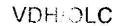
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID. VA0105

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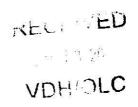
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ACCOUNT OF THE PARTY OF THE PAR | CONSTRUCTION | | TÉ SURVEY MPLETED |
|--------------------------|---|---|--|---|----------|----------------------------|
| | | 495323 | B. WING | | 0 | C 4/25/2019 |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAI | pows | STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | 1 0 | */25/2015 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 580 | evidence that the slid administered. There the eMAR that the slid administered. The 3/12/19 4:30 p.m resident. There was had been informed. been administered 3 The 3/13/19 6:00 a.m resident. There was had been informed on The 3/15/19 6:00 a.m resident. There was had been informed on The 3/16/19 6:00 a.m resident. There was had been informed on The 3/17/19 6:00 a.m resident. There was had been informed on The 3/19/19 4:30 p.m refused by the resident the physician had been the side the physician had be the physician had be the side | s was 209 . BS was 212. gar results did not have ding scale insulin was was no documentation on ding scale insulin had been an evidence the physician Resident #25 should have units of SSI. In insulin was refused by the no evidence the physician of the refusal. In insulin was refused by the no evidence the physician of the refusal. In insulin was refused by the no evidence the physician of the refusal. In insulin was refused by the no evidence the physician of the refusal. In insulin was refused by the no evidence the physician of the refusal. In and 8:30 p.m. insulin was ent. There was no evidence the informed of the refusal. In and 4:30 p.m. insulin was ent. There was no evidence the en informed of the refusal. | F 580 | | | |
| | refused by the reside the physician had be The surveyor informe nursing of the above | n. and 11:30 a.m. insulin was nt. There was no evidence en informed of the refusal. In the interim director of concern on 4/25/19 at 10:43 the physician's orders for on March and April | | | | ; |

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

Event ID. XQ8811

Facility ID. VA0105

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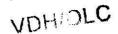
PRINTED: 05/15/2019 FORM APPROVED OMB NO. 0938-0391

| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE COI | | (X3) DATE SURV COMPLETED | |
|--------------------------|--|--|-------------------|--|--|---------------|
| | | 495323 | B. WING | | 04/25/2 | 019 |
| | ROVIDER OR SUPPLIER | pows | 16600 LAU | ET ADDRESS, CITY, STATE, ZIP CODE D DANVILLE PIKE REL FORK, VA 24352 | | (X5) |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE CO | MPLETION DATE |
| F 684 | Continued From pag | | F 684 | , | 3 | |
| | applies to all treatment facility residents. Bate assessment of a residents received accordance with propractice, the compressive discourage plan, and the resident review, a facility staff failed to of 18 residents (Residents for TED hose thromboembolic discourage for TED hose thromboemboli | indamental principle that ent and care provided to ised on the comprehensive sident, the facility must ensure we treatment and care in offessional standards of shensive person-centered esidents' choices. IT is not met as evidenced ion, staff interview, facility and clinical record review, the follow physician orders for 2 sident #54 and Resident #25). Ed: failed to follow physician's experimental for Resident #54. of Resident #54 was reviewed its for Resident #54 was lity 6/5/15 and readmitted in ses that included but not piratory failure, protein-calorie malnutrition, ronephrosis, bipolar disorder, isorder, hypertension, anxiety, | | Corrective Action(s): Resident #54's attending phy notified that the facility staff apply resident 54's TED stoophysician order. A facility In Accident form was complete incident. Residents #25's attending phy notified that the facility faile TED stockings per physician to obtain orthostatic blood puphysician order and failed to attending physician order and failed to attending physician of daily changes of 3-5 pounds per porder. A facility Incident & form was completed for this Identification of Deficient Practices/Corrective Action All other residents with phy TED Stocking, Daily weigh orthostatic blood pressure of have potentially been affect and Unit Manager will contained at the process of all resident's physic MAR's to identify resident Residents identified at risk corrected at time of discoverattending physician will be each negative finding and a Incident & Accident Form completed for each negative | failed to cking per cident & d for this lysicians was d toapply lorder, failed ressures per notify the weight hysician Accident incident. n(s): sician ordered t orders and rders may ed. The DON, luct a 100% cian orders and at risk. will be cry and the notified of facility will be | |

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

Event ID: XQ8811

Facility ID: VA0105



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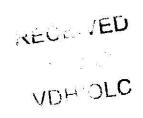
| STATEMENT O | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE C | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|--|---|--|
| -442 CV4 OF | <u> </u> | | A BUILDING | | С | |
| | | 495323 | B. WING | | 04/25/2019 | |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAD | pows | 166 | REET ADDRESS, CITY, STATE, ZIP CODE 00 DANVILLE PIKE UREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | SE COMPLETION | |
| F 684 | Continued From pag thinking but without of behaviors that affect Resident #54's curre identified ADL (activity potential concern with include TED hose-or (evening). The April 2019 physorder dated 3/26/19 morning) and off qprice The surveyor observat 2:21 p.m. Reside activity area near this search. The surveyon the resident and not on. The surveyon the resident and not on. The surveyon again at 4:22 p.m. I was asked to check stated, "No TED hose are put on at bedtim The surveyor informinterim director of no coordinator, and the the above concern of the surveyor concern of the | e 9 evidence of psychosis or ed others. Int comprehensive care planties of daily living) as a chinterventions listed to in in am (morning), off in pm Ician's orders included an for TEDs on qam (every m (every evening). Int #54 was sitting in the etelevision doing a word or did not observe TED hose the resident stated they were or observed Resident #54 Licensed practical nurse #1 for the TED hose. L.P.N. #1 se on." Resident #54 stated had not been put on. "They | F 684 | | s have e g by the n in the remains opment f care, ibing red DON will f on the ing, and and wing the ht od | |
| | The facility staff orders for TED hose blood pressures for | | | | | |
| | | of Resident #25 was reviewed | | | N 10 | |

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

Event ID: XQ8811

Facility ID: VAD105

If continuation sheet Page 10 of 30



PRINTED: 05/15/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | NOTE OF THE PROPERTY | PLE CONSTRUCTION | | E SURVEY PLETED | | |
|---|---|---|---------------------|--|---|----------------------------|
| AND PLAN OF | CORRECTION | IDENTIFICATION NUMBER: | A, BUILDIN | G | 1 | С |
| | | 495323 | B. WING | | 04 | /25/2019 |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAU | pows | | STREET ADDRESS, CITY, STATE, ZIP CO 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | DE | |
| (X4) 1D PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY | ON SHOULD BE IE APPROPRIATE | (X5) COMPLETION DATE |
| F 684 | 4/23/19 through 4/25 admitted to the facilitis 3/11/19 with diagnos limited to type 2 dial pubis, heart failure, a chronic ischemic herobstructive pulmona kidney disease (stag Resident #25's adm (MDS) assessment reference date (ARI resident with a BIMS status) as 15/15. Resymptoms of deliriur affecting others. Resident #25's curr was reviewed. Block were not addressed Resident #25's curr was reviewed. The with weight fluctuation were in part to mon (A) Resident #25's telephone order dai read in part "TEDs apm (every evening). The surveyor observed wheelchair with bot surveyor did not obresident. The surveyor and the surveyor | 5/19. Resident #25 was ty 11/28/15 and readmitted sis that included but not betes mellitus, fracture of right atrial fibrillation, edema, art disease, chronic any disease, and chronic ge III). ission minimum data set with an assessment D) of 3/18/19 assessed the S (brief interview for mental esident #25 had no signs or m, psychosis, or behaviors ent comprehensive care plan and pressures or TED hose I on the current care plan erare plan identified nutrition ions as a risk and approaches itor weights, labs, and intakes. clinical record included a ted 4/23/19 at 2:00 p.m. that qam (every morning) and off | F | Monitoring: The DON will be responsi maintaining compliance. I and/or Unit Managerwill I MAR audits on all resider for compliance. Any/all n and or errors will be corrediscovery and disciplinary taken as needed. Aggregathese audits will be report Quality Assurance Common for review, analysis, and recommendations for chapolicy, procedure, and/or Completion Date: June | the DON, perform weekly at to monitor egative findings betted at time of a y action will be atte findings of ted to the nittee quarterly ange in facility practice. | |

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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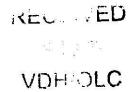
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 0.3 0.70220788 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED C | |
|--------------------------|--|---|--------------------|-----|---|------------------------------|----------------------------|
| | | 495323 | B. WING_ | | | 04/2 | 5/2019 |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAD | oows | | 16 | TREET ADDRESS, CITY, STATE, ZIP CODE 5600 DANVILLE PIKE AUREL FORK, VA 24352 | | |
| (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 APPROPR DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 684 | Resident #25 did not stated she had not he resident stated nobor. (B). Resident #25's A read in part "Orthost taken daily-start date. A review of the April administration record blood pressures obtalying only. The survey blood pressures for the positions. The vital serviewed for April 20 no type of blood pressure form had blood pressure of untime difference on the lying BP and the second greater. The surveyor informations and the comparison of the compari | have TED hose on and ad them all day. The dy put them on her. April 2019 physician's orders atic blood pressure to be 3/11/19." 2019 medication of found that the results for ained while the resident was eyor was unable to locate the sitting and standing signs summary form was 19. One summary form had assure documented, another soure-lying documented, and a blood pressures and then a know type documented. The is third form between the cond BP was an hour or led the interim director of porate registered nurse on | F | 684 | | | |
| | interim DON when o were ordered what be obtained. The interim and standing. The interim DON standinical record that the "orthostatic blood pressuration blood pressurations of the surveyor requestions of the surveyor requestions of the surveyor requestions." | The surveyor asked the rthostatic blood pressures blood pressures should be in DON stated lying, sitting sited after reviewing the second pressure but that only the re had been obtained. Sted the facility guidance for blood pressures. The MDS If the following to the surveyor | | | | | |

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Event ID: XQ8811

Facility ID: VA0105

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| | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CON | ESTRUCTION | (X3) DATE SURVEY COMPLETED | | |
|--------------------------|--|---|---------------------|--|-----------|----------------------------|
| | | 495323 | B. WING | | 04/ | 25/2019 |
| 992VII 1705 | ROVIDER OR SUPPLIER E HALL - LAUREL MEAS | pows | 16600 | ET ADDRESS, CITY, STATE, ZIP CODE DANVILLE PIKE REL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 684 | on 4/25/19 at 10:36 Blood Pressure Edu Institute of Health (2 hypotension (posturi sudden drop of 25 m in systolic pressure pressure when the of sitting or a sitting to Orthostatic hypotension and is a common ar several medications hydrochloride. Whe pressure: Place the 5 minutes to allow for pressure, and measi pressure, and measi pressure. Assist the and wait 1 minute to initial orthostasis, the blood pressure. Re minutes to allow for mechanisms to com any orthostasis. (C). The facility state order to notify the p gained 3-5 pounds. The April 2019 phys weights report weigh Doctor." The surveyor review weights. Resident on 4/11/19 to 139.7 difference of 8 pour documentation of the physician in the 4/12/19. There wa | a.m. from the National High cation Program, National 003) and read "Orthostatic all hypotension) refers to a mm (millimeters) Hg (mercury) and 10 mm Hg in diastolic client moves from a lying to a a standing position. Sion usually occurs with aging a standing position. Sion usually occurs with aging a such as chlorpromazine as measuring orthostatic blood a client in a supine position for or equilibrium of the blood are the pulse and blood as client to a standing position, to obtain a full evaluation of the pen recheck the pulse and beassess the vital signs after 2 an evaluation of the client's appensate for the presence of | F 684 | | | |

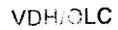
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VA0105

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| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A03 - 0.00 5100 | TIPLE CONSTRUCTION NG | | TE SURVEY MPLETED C |
|--------------------------|--|--|-------------------|--|--|----------------------------|
| | | 495323 | B, WING | | 10000 10 10 10 10 10 10 10 10 10 10 10 1 | 4/25/2019 |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAL | pows | | STREET ADDRESS, CITY, STATE, ZII 18500 DANVILLE PIKE LAUREL FORK, VA 24352 | P COD€ | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | SOURCE SECTION TO | ACTION SHOULD BE TO THE APPROPRIATE | (X5) COMPLETION DATE |
| F 684 | practitioner on that of for anemia but for differ and but for differ anemia but for differ anemia but for differ and the surveyor informitter and the the above concerning blood pressures and blood pressures and document and the differ and but for differ and but for differ and the differ and diffe | ary with medication changes uresis. If from 130.2 pounds on ands on 4/15/19-a difference surveyor found no the physician was made gain. The MD was made aboratory results but there on about the resident's ne physician's orders. If from 132.1 pounds on ands on 4/19/19 - a difference 4/19/19 1:37 p.m. note stated en on rounds and a new order 60 mg (milligrams) q am | F | 684 | | |

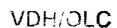
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VA0105

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| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|--------------------------|--|--|---------------------|---|--|
| | | | A DOLDANG | <u> </u> | C |
| -A7*** - 134*** | | 495323 | B. WNG_ | | 04/25/2019 |
| | ROVIDER OR SUPPLIER | ows | | STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AL DEFICIENCY) | HOULD BE COMPLETION |
| F 684 F 690 SS=D | exit conference on 4/ Bowel/Bladder Incon CFR(s): 483.25(e)(1) §483.25(e) Incontine §483.25(e)(1) The fa resident who is conti admission receives s maintain continence | n was provided prior to the 725/19. tinence, Catheter, UTI (-(3)) ence. delity must ensure that the nent of bladder and bowel on services and assistance to unless his or her clinical these such that continence is | F 6 | | 54 now has place with resident's |
| | ensure that- (i) A resident who er indwelling catheter is resident's clinical co- catheterization was (ii) A resident who e indwelling catheter is assessed for remandation as possible unless that cand (iii) A resident who is receives appropriate prevent urinary tracticentinence to the existence of the existence | on the resident's assment, the facility must an a not catheterized unless the addition demonstrates that necessary; anters the facility with an or subsequently receives one avail of the catheter as soon the resident's clinical condition atheterization is necessary; as incontinent of bladder a treatment and services to a infections and to restore tent possible. | | accurate Foley Catheter size catheter balloon size. A facil & Accident form was complinated and Corrective Action(s): All other residents with a Fomay have been potentially and DON and or Unit Manager vil 100% review of all residents catheter to identify residents Residents discovery and discip with be taken as warranted. Incident & Accident Form veach negative finding. | and correct ity Incident eted for this Practice(s) ley catheter ffected. The will conduct a s with a Foley at risk. corrected at olinary action a Facility |

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Event ID: XQ8811

Facility ID: VA0105

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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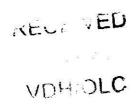
| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | IPLE CONSTRUCTION | (X3) DATE COMPI | LETED | |
|--|--|---|---------------------|---|---|----------------------------|
| | | 495323 | B. WING_ | | 1 | 25/2019 |
| | ROMDER OR SUPPLIER E HALL - LAUREL MEAD | pows | | STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | SHOULD BE | (X5) COMPLETION DATE |
| F 690 | by: Based on observation document review, are facility staff failed to for the size of an individual balloon for 1 of 18 resident The findings include. The facility staff failed for the size of the incident of of the inc | T is not met as evidenced on, staff interview, facility and clinical record review, the follow the physician's orders welling Foley catheter esidents (Resident #54). d: d: d: d: d: fResident #54 was reviewed 5/19. Resident #54 was ity 6/5/15 and readmitted ses that included but not oiratory failure, orotein-calorie malnutrition, renephrosis, bipolar disorder, sorder, hypertension, anxiety, and pneumonia. dission minimum data set with an assessment D) of 3/19/19 assessed the S (brief interview for mental core as 14/15. Resident #54 inattention, disorganized evidence of psychosis or ded others. ent comprehensive care plan em of urinary incontinency, in part "3/25/19 Clarification r) 18 Fr (French) Change | F | Systemic Change(s): The facility Policy and Pro Foley/Suprapubic Catheter usage and care has been re changes are warranted at the nursing staff will be inserved by the proper of the policy and proper of the using the proper balloon size when inserting physician ordered Foley cannot be discounted to foley cannot be corrected at time of discounted to the Quality As Committee for review, and recommendations for change of the policy, procedure, and/or Completion Date: June 1 | r insertion, eviewed and no his time. The viced by the ocedures for and care to er catheter ag or changing a atheter. s responsible for The DON and/or n monthly er's to monitor ive findings will acovery. andit will be ssurance alysis, and age in facility practice. | |

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Event ID: XQ8811

Facility ID: VA0105

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| CENTERS FOR MEDICAR | E & MEDICAID SERVICES | 30000 W | OMB NO. 0938-0391 |
| CENTERS I OR MEDICAL | L & MLDIONID OLIVINGLE | CONTRACTOR E CONSTRUCTION | (X3) DATE SURVEY |
| | | | |

| | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIE/CLIA IDENTIFICATION NUMBER: | | | | COMPLETED | |
|--|---|--|---|---|-------------|----------------------------|--|
| AND FEMALOR | CORRECTION | | A BUILDIN | <u> </u> | ŀ | l c | |
| | | 495323 | B. WING _ | | 0 | 4/25/2019 | |
| A Property of the Control of the Con | ROVIDER OR SUPPLIER | EADOWS | | STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | Ē | | |
| (X4) ID PREFIX TAG | | | SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COR (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION | | I SHOULD BE | (XS) COMPLETION DATE | |
| F 690 | Continued From p | page 16 | F 6 | 590 | | | |
| | order dated 3/25/ | nysician's orders included an 19 for Foley cath 18 Fr/10 cc s) balloon change q (every) s needed). | | | | | |
| | at 12:30 p.m. Re nursing assistant resident for anch catheter. C.N.A. anchored. Both noted the size of | served Resident #54 on 4/23/19 sident #54 was in bed. Certified #1 was asked to check the orage and size of the Foley #1 stated the Foley catheter was the surveyor and C.N.A. #1 the catheter was 18 Fr with a 30 to co balloon as ordered. | <u>.</u> | | , | | |
| 140 | checked the indv at 4:06 p.m. The cc balloon. The | d the interim director of nursing velling Foley catheter on 4/24/19 Foley size was 18 Fr with a 30 interim DON stated the balloon and then stated, "I hope I didn't | | | | | |
| | | quested the April 2019 physician's re plan and the facility policy on | | | | | |
| | interim director of coordinator, and | ormed the administrator, the of nursing, the minimum data set the corporate registered nurse of or on 4/25/19 at 12:51 p.m. | | | | | |
| | Female Resider policy read in pa is a physician's | y titled "Foley Catheter Insertion, it" was reviewed 4/25/19. The int "Preparation 1. Verify that there order for this procedure." | | | | | |
| | No further inform | nation was provided prior to the | | | | | |

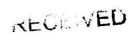
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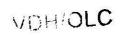
exit conference on 4/25/19.

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Facility ID: VA0105

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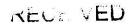
| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA SDENTIFICATION NUMBER: | CONTRACTOR CONTRACTOR | PLE CONSTRUCT | | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|---|---|---|--|--|----------------------------|
| | | | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | | | 0 | |
| | | 495323 | B. WING_ | | and the second s | 04/2 | 5/2019 |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAD | ows | 100 | 16600 DANVIL | ESS, CITY, STATE, ZIP CODE LLE PIKE RK, VA 24352 | | 260. |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | | PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD I OSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 756 F 756 SS=D | Drug Regimen Revie CFR(s): 483.45(c)(1) §483.45(c) Drug Reg §483.45(c)(1) The drust be reviewed at licensed pharmacist. §483.45(c)(2) This re of the resident's med §483.45(c)(4) The prirregularities to the affacility's medical directly and these reports mu (i) Irregularities including that meets the c (d) of this section for (ii) Any irregularities during this review museparate, written repattending physician adirector and director minimum, the resider and the irregularity th (iii) The attending physician adirector has been take be no change in the physician should door the resident's medical section for (iii) The attending physician should door the resident's medical reirregularity has been action has been take be no change in the physician should door the resident's medical section for (iii) The famaintain policies and drug regimen review limited to, time frame | w, Report Irregular, Act On (2)(4)(5) imen Review. ug regimen of each resident least once a month by a view must include a review ical chart. narmacist must report any tending physician and the ctor and director of nursing, ust be acted upon. Ide, but are not limited to, any criteria set forth in paragraph an unnecessary drug, noted by the pharmacist ust be documented on a cort that is sent to the and the facility's medical of nursing and lists, at a not's name, the relevant drug, he pharmacist identified. If you want the identified reviewed and what, if any, and to address it. If there is to medication, the attending cument his or her rationale in | | Res PRI by t pha mer not mer app rev: for Ide Coi All mei affe wil and ide ide psy atte pha adi Ac neg Th beer wa num reg Fe- rev me | indent #33 has had their routine and psychotropic medications reviewed administer PRN psychotropic dications longer than 14 days with the attending physician and continuation regime has been clarifications longer than 14 days with the attending physician follow up an iew. A facility Incident and Accommass been completed for this intentification of Deficient Practications are physician follow up an iew. A facility Incident and Accommass been completed for this intentification of Deficient Practications may have been potent extended. The DON and Unit Manal I review all residents receiving a PRN psychotropic medications reviewed and intentified at risk will have their exchotropic medications reviewed ending physician and/or consultarmacists to make corrections and usustments. A facility Incident & cident form will be completed for gative finding. Stemic Change(s): The DON and Procedure en reviewed and no changes are urranted at this time. The DON are griefly pointed and responsibility pointed and resident on the rederial Regulations for drug regiments and the use of PRN psychological and the attending physician. | iewed sultant tropic ed to ithout d ident ocident. It ces & otropic ially ger routine is to ents id by the ant od/or for each that it could be incorrected in the otropic ially ger routine is to ents in the incorrected in the otropic in the otropi | |

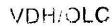
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VA0105

If continuation sheet Page 18 of 30





PRINTED: 05/15/2019 FORM APPROVED OMB NO. 0938-0391

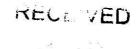
| STATEMENT | OF DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | - All 198 | X2) MULTIPLE CONSTRUCTION | | |
|--------------------------|--|---|---------------------|--|--|--|
| AND PLAN OI | F CORRECTION | IDENTIFICATION NUMBER: | A, BUILDING | | С | |
| | | 495323 | B. WING | | 04/25/2019 | |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEA | Dows | 1660 | EET ADDRESS, CITY, STATE, ZIP CODE DO DANVILLE PIKE JREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | OULD BE COMPLETION | |
| F 756 | requires urgent actic This REQUIREMEN by: Based on staff inter and facility documen pharmacist failed to there was any chan medications orderer 14 days for 1 of 18 The findings include Resident #33 was r 3/18/19 with the foll limited to high blood urinary tract infection disorder, depression the quarterly MDS ARD (Assessment the resident was co Interview for Menta possible score of 1 coded as requiring members for dress being totally depen bathing. During the clinical surveyor noted the Resident #33: o"Haldol 1 r hours pm (as need (times) 1 hour oAtivan 0.5 | ntifies an irregularity that on to protect the resident. IT is not met as evidenced review, clinical record review nt review, the contracted document whether or not ge for psychotropic d for prn (as needed) use for residents (Resident #33). ed: readmitted to the facility on lowing diagnose of, but not d pressure, heart failure, on, diabetes, stroke, anxiety in and psychotic disorder. On (Minimum Data Set) with an Reference Date) of 3/26/19, oded as having a BIMS (Brief of Status) score of 7 out of a 5. Resident #33 was also extensive assistance of 2 staffing and personal hygiene and dent on 2 staff members for record review on 4/25/19, the following physician order's for mg po (by mouth) q (every) 4 led) anxiety. May repeat X mg (milligram) SL (sublingual) ety may repeat X 1 in 30 | F 756 | Monitoring: The DON is responsible for ma compliance. The DON and/or Manager will perform monthly all residents receiving psychoth medications to ensure that the appropriate and that PRN psycare not used for more than 14 time without physician review approval for continued use. An negative finding will be correctly of discovery and disciplinary abe taken as needed. Detail find review will be reported to the Assurance Committee for revianalysis, and recommendation change in facility policy, procand/or practice. Completion Date: June 7, 26 | Unit y audits of ropic usage is shotropics days at a and ny/all cted at time action will dings of this Quality iew, as for cedure, | |

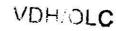
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VA0105

If continuation sheet Page 19 of 30





PRINTED: 05/15/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT O | F DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|--|--|---------------------|--|---|--|
| | | 405222 | B. WING | | C 04/25/2019 | |
| | OVIDER OR SUPPLIER | 495323 DOWS | ST 16 | REET ADDRESS, CITY, STATE, ZIP CODE 600 DANVILLE PIKE AUREL FORK, VA 24352 | 04/23/2013 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE COMPLETION | |
| F 756 | facility staff on 3/19/ The contracted phar Medication Regimer was a written in notal The surveyor noted from the contracted The surveyor notifie the above documen 12:50 pm. No further informatic surveyor prior to the Free from Unnec Ps CFR(s): 483.45(c)(3) A psy affects brain activity processes and behabut are not limited to categories: (i) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-depressant; (iv) Hypnotic Based on a compreresident, the facility \$483.45(e)(1) Resident, the facility sychotropic drugs unless the medicat | an gave these orders to the 19. macist performed a Review on 4/8/19. There ation that stated "hospice". no further recommendations pharmacist. d the administrative team of ted findings on 4/25/19 at the exit conference on 4/25/19. Sychotropic Meds/PRN Use 8)(e)(1)-(5) propic Drugs. Propic Drugs. Prohotropic drug is any drug that the associated with mental avior. These drugs include, or, drugs in the following the dents who have not used are not given these drugs ion is necessary to treat a stating diagnosed and documented. | F 758 | F758 Corrective Action(s): Resident #33 has had their routine ar PRN psychotropic medications revie by the Hospice physician, the attendiphysician and consultant pharmacist. Resident #33's regime has been clart to not administer PRN psychotropic medications longer than 14 days wit appropriate physician follow up and review. A facility Incident and Accidion has been completed for this incompleted for this incompleted for the psychotropic medications may have potentially affected. The DON and Manager will review all residents receiving routine and PRN psychotropic medications to identify residents at All residents identified at risk will a their psychotropic medications review the attending physician and/or consultant pharmacists to make corrections and/or adjustments. A formulated for each negative finding | wed ing ified hout dent cident es & ee and been Unit ropic risk nave ewed acility | |

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Event ID: XQ8811

Facility ID: VA0105

If continuation sheet Page 20 of 30



PRINTED: 05/15/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT O | F DEFICIENCIES | (X1) PROVIDER/SUPPLIER/CLIA | 1 2 5 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|---|--|---------------------|---|---|----------------------------|
| ANU PLAN OF | CORRECTION | | | | C | 5/0048 |
| • | | 495323 | B. WING | STREET ADDRESS, CITY, STATE, ZIP CODE | 1 04/2 | 5/2019 |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAI | pows | | 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 758 | drugs receive gradu behavioral interventi contraindicated, in a drugs; §483.45(e)(3) Resid psychotropic drugs unless that medicati diagnosed specific oin the clinical record §483.45(e)(4) PRN are limited to 14 day §483.45(e)(5), if the prescribing practitio appropriate for the beyond 14 days, he rationale in the residindicate the duration §483.45(e)(5) PRN | ents who use psychotropic al dose reductions, and ions, unless clinically an effort to discontinue these dents do not receive pursuant to a PRN order ion is necessary to treat a condition that is documented it; and orders for psychotropic drugs ys. Except as provided in eattending physician or oner believes that it is PRN order to be extended to or she should document their dent's medical record and in for the PRN order. | F 75 | Systemic Change(s): The facility Policy and Procedure been reviewed and no changes ar warranted at this time. The Hosp provider, the DON and the nursir have been inserviced by the region nurse consultant on the revised F Regulations for drug regime revithe use of PRN psychotropic meet for no more than 14 days at a time without further review and approthe Hospice Physician and/or attemphysician. Monitoring: The DON is responsible for main compliance. The DON and/or Un Manager will perform monthly a | e ice ig staff mal ederal ew and dication e val from ending | |
| | drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on facility document review, staff interview and clinical record review, the facility staff failed to ensure that 1 of 18 residents in the survey sample was free from receiving prn/as-needed psychotropic medications for longer than 14 days (Resident #33). The findings included: The facility staff failed to ensure Resident #33 | | | all Hospice residents receiving psychotropic medications to ensure usage is appropriate and that PRI psychotropics are not used more days at a time without physician and approval for continued use. A negative finding will be corrected of discovery. Detailed findings of review will be reported to the Quantum Assurance Committee for review analysis, and recommendations for change in facility policy, proceduland/or practice. Completion Date: June 7, 2019 | n than 14 review Any/all d at time f this sality or | |

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

Event ID: XQ8811

Facility ID: VA0105

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PRINTED: 05/15/2019 FORM APPROVED OMB NO. 0938-0391

| CENTER: | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO. 0938-0391 | |
|--------------------------|---|--|-------------------|-------|---|-------------------|----------------------------|
| TATEMENT C | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | NG | STRUCTION | 25.000 | SURVEY PLETED |
| | | 495323 | B. WING | | | 044 | 25/2019 |
| | ROVIDER OR SUPPLIER E HALL - LAUREL MEAI | pows | 1 | 16600 | ET ADDRESS, CITY, STATE, ZIP CODE DANVILLE PIKE REL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY) | D BE | (X5) COMPLETION DATE |
| F 758 | was free from receive psychotropic medical Resident #33 was re 3/18/19 with the folk limited to high blood urinary tract infection disorder, depression the quarterly MDS (ARD (Assessment of the resident was contrerview for Mental possible score of 15 coded as requiring members for dressibeing totally dependently dependently and the Resident #33: "Haldol 1 mg poopm (as needed) and hourAtivan 0.5 mg (mours promanaies and the Hospice physicallity staff on 3/15. The Corporate Nurnursing) was notifical findings on 4/25/15 requested and recommendently marked and recommendently requested | ring prn/as-needed ations for longer than 14 days. Eadmitted to the facility on owing diagnose of, but not pressure, heart failure, n, diabetes, stroke, anxiety of and psychotic disorder. On Minimum Data Set) with an Reference Date) of 3/26/19, ded as having a BIMS (Brief I Status) score of 7 out of a street #33 was also extensive assistance of 2 staffing and personal hygiene and dent on 2 staff members for ecord review on 4/25/19, the following physician order's for (by mouth) q (every) 4 hours exiety. May repeat X (times) 1 milligram) SL (sublingual) q 2 may repeat X 1 in 30 minutes if exiety" | F | 758 | | | |

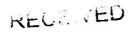
FORM CMS-2567(02-98) Pravious Versions Obsolete

doses for psychotropic medications unless that

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Fecility ID: VA0105

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| 8 | S FOR MEDICARE & F DEFICIENCIES | MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) MULT | IPLE COI | VISTRUCTION | (X3) DATE | SURVEY LETED |
|--------------------------|---|--|--------------------|----------|--|--|----------------------------|
| AND PLAN OF | | IDENTIFICATION NUMBER: | A. BUILDII | NG | | 3 37.08.29.408 | |
| | | 495323 | B, WING | 18 | 25/2019 | | |
| NAME OF PR | OVIDER OR SUPPLIER | 435323 | | STRE | ET ADDRESS, CITY, STATE, ZIP CODE | | 25/2015 |
| | | | | 16604 | DANVILLE PIKE | | |
| HERITAGE | HALL - LAUREL MEA | DOWS | | LAU | REL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENT | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | 15-000 | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO! CROSS-REFERENCED TO THE APPR DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 758 | medication is necessary to treat a specific condition that is documented in the clinical record The need to continue PRN orders for | | F | 758 | | | |
| 32 | the healthcare practifor the extended order will be indicated PRN orders for antiple renewed beyond healthcare practition for the appropriaten. The surveyor notifies | psychotic medications will not | | | | | |
| F 812 SS=E | surveyor prior to the Food Procurement, CFR(s): 483.60(i)(1) §483.60(i) Food sat The facility must - §483.60(i)(1) - Procuper of the facility must - §483.60(i)(1) - Procuper | fety requirements. cure food from sources lered satisfactory by federal, rities. e food items obtained directly rs, subject to applicable State | F | 812 | Corrective Action(s): All undated, unlabeled, expired identified in the Dry-storage ar the initial kitchen tour that wer properly labeled or out of date removed and disposed of. A far Incident and Accident form was completed for this incident. Identification of Deficient Precorrective Action(s): All other food items in may had potentially affected. The Food Manager, and/or Registered Disinspect the kitchen dry storage walk-in freezer, reach in freezer refrigerators to identify any nefindings. All negative findings corrected at time of discovery. Incident and Accident form with completed for each negative findings. | ea during e not have been cility ts actices & ve been Service ictician will areas, the ers and egative the will be A facility ill be | |

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Event ID: XQ8811

Facility ID: VA0105

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| CENTER | S FOR MEDICARE & | MEDICAID SERVICES | | | | OMB NO | 0938-0391 |
|--------------------------|---|--|--------------------|---|--|--------|----------------------------|
| | OF DEFICIENCIÉS F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | SURVEY ETED |
| | _ | 495323 | B. WNG_ | | <u> </u> | 04/2 | 25/2019 |
| MAR SER IN | ROVIDER OR SUPPLIER E HALL - LAUREL MEAD | oows | 5.00 5.00 9.00 | 166 | EET ADDRESS, CITY, STATE, ZIP CODE 00 DANVILLE PIKE JREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 812 | standards for food set This REQUIREMENT by: Based on observation and staff interview, it spices when opened spices. The findings included The facility staff failed opened and failed to expired. The surveyor toured beginning at 10:15 a manager and the dietary manager manager observed was pice observed was Pepper spice that he Further observation Rosemary that had a surveyor asked both expectations were we The assistant dietar including spices were when opened. The surveyor observed and noted the | ervice safety. T is not met as evidenced on, facility document review he facility staff failed to date and failed to discard expired d: d to date spices when discard spices that had the kitchen on 4/23/19 h.m. with the assistant dietary atary manager. The surveyor, and assistant dietary a shelf with spices. The first 28 ounces of Lemon and ad no date when opened. The dietary staff what their with dating food when opened. It manager stated food the to be dated and labeled wed the contents of the spice | F | B12 | Systemic Change(s): Current facility policy & procedure h been reviewed and no changes are warranted at this time. The consulting Registered Dietician and/or Dietary manager will inservice the dietary stathe proper preparing, storing and distribution of food under sanitary conditions, as well as the policy for proper food storage to include proper labeling and dating. The inservice wi also include all aspects of infection & sanitation control measures. Monitoring: The CDM is responsible for maintain compliance. The Administrator and/Food service manager will complete Dietary audit tool weekly for monito and maintaining compliance. The re of these audits will be reported to the Quality Assurance Committee for reanalysis, & recommendations for chain facility policy, procedure, and/or practice. Completion Date: June 7, 2019 | off on | |
| | Onion powder 20 ou Ground oregano 11 opened. Hungarian Paprika opened. | ounces. No date when opened. 8 ounces. No date when | | | | | |

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

Date on the container read "Sent 4/16/19."

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Facility ID: VA0105

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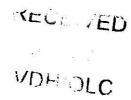
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | | | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
|--|---|--|---------------------|---|---------------------------------|------------------------------|--|
| | | 495323 | B. WING | <u> </u> | 0 | 4/25/2019 | |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS | | | | STREET ADDRESS, CITY, STATE, ZIP CO 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | ODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC | ION SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 812 | Seasoning salt 38 opened. Ginger 15 ounces. Cumin 16 ounces. Sage 6 ounces with Ground mustard 15 7/5/18. Thyme 13 ounces of Chili powder 18 out Black pepper 18 out Many of the spices as to when they we or unreadable. The surveyor requedating of food from The surveyor revie "Section CIII-Food Labeling, Dating Foread in part under be dated upon receipt should be received by the receipt should be received | No date when opened. Dated to be used by 2/9/16. In a use by date of 8/4/18. It counces with a use by date of owith use by date of 7/1/18. Inces. No date when opened. Inc | F 8 | | | | |

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

Event ID: XQ8B11

Facility ID: VA0105

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED C | |
|--|---|---|---|---|--|----------------------------|
| 495323 | | B. WING_ | 1 N-1 | 04/25/2019 | | |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | HOULD BE | (XS) COMPLETION DATE |
| F 842 SS=D | The surveyor information interim director of nu coordinator and the other above concern of the accordance on the facility may be resident-identifiable accordance with a congress not to use or except to the extent to do so. §483.70(i) Medical of \$483.70(i) (1) In according the accordance with a congressional standar must maintain medithat are- (i) Complete; (ii) Accurately document of the accordance of the extent of the exten | ed the administrator, the ursing, minimum data set corporate registered nurse of an 4/24/19 at 3:00 p.m. In was provided prior to the 4/25/19. Identifiable Information (a, 483.70(i)(1)-(5) ent-identifiable information. release information that is to the public. release information that is to an agent only in contract under which the agent of disclose the information. The facility itself is permitted records. ordance with accepted rds and practices, the facility cal records on each resident mented; ble; and organized acility must keep confidential ained in the resident's records, orm or storage method of the en release is- | | F842 Corrective Action(s): Resident #25's attending phy been notified that the facility to notify and document when had daily weight changes per order. A facility incident and form has been completed for Identification of Deficient If Corrective Action(s): All other residents may have been affected. A 100% revier residents with physician orde weights will be conducted by and/or Unit Manager to iden at risk for inappropriate document and physician notification. A findings will be clarified and time of discovery. A facility Accident form will be comp negative finding. | staff failed resident #25 physician accident this incident. Practices & potentially w of all ered daily y the DON tify residents umentation All negative d/or correct at Incident & | |
| | (ii) Required by Lav | re permitted by applicable law; v; payment, or health care | | | | |

FORM CMS-2557(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VA0105

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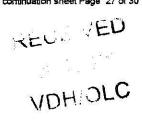
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (XZ) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
|--|---|---|---|-----|---|---|----------------------------|
| | | 495323 | B. WING | | | C 04/25/2019 | |
| NAME OF B | DOMNED OD SLIDBUIED | 499353 | B. WING . | ST | REET ADDRESS, CITY, STATE, ZIP CODE |) 04/ | 25/2019 |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS | | | | 16 | 6600 DANVILLE PIKE AUREL FORK, VA 24352 | | 32 |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREF TAG | 55 | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 842 | operations, as permit with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research predical examiners, a serious threat to be by and in compliance §483.70(i)(3) The far record information a unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from the there is no requirem (iii) For a minor, 3 ye legal age under State §483.70(i)(5) The medical graph of the record | tited by and in compliance 5; activities, reporting of abuse, violence, health oversight diadministrative proceedings, poses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted ewith 45 CFR 164.512. cility must safeguard medical gainst loss, destruction, or all records must be retained exercised by State law; or the date of discharge when ent in State law; or ears after a resident reaches the law. edical record must containtion to identify the resident; esident's assessments; sive plan of care and services my preadmission screening evaluations and lucted by the State; e's, and other licensed | F | 842 | Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on clinical documentation standards per facility policy and procedure. This inservice will include the standards for proper notification and documentation physician ordered weight changes. Monitoring: The DON is responsible for maintain compliance. The DON and/or design will andit medical records weekly coinciding with the care plan calendary monitor for compliance. Any/all neg findings will be clarified and correct time of discovery and disciplinary as will be taken as needed. The results this audit will be provided to the Quantum Assurance Committee for analysis as recommendations for change in facili policy, procedure, and/or practice. Completion Date: | the or on of ing one ar to ative ed at stion of ality | |

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

Event ID: XQ8811

Facility ID: VA0105

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CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/15/2019 FORM APPROVED OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 989-89-892090 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | E SURVEY PLETED |
|--|--|---|--------------------|--|------------------------------------|----------------------------|
| | | 495323 | B. WING | | 04 | C /25/2019 |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS | | | | STREET ADDRESS, CITY, STATE, ZIP 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | BTTT | CTION SHOULD BE THE APPROPRIATE | (XS) COMPLETION DATE |
| F 842 | complete and accurar residents (Resident # The findings included The facility staff failed record of Resident #2 staff failed to docume when the physician with changes for Resident The clinical record of 4/23/19 through 4/25 admitted to the facility 3/11/19 with diagnosi limited to type 2 diabout pubis, heart failure, a chronic ischemic hear obstructive pulmonar kidney disease (staged Resident #25's admitted (MDS) assessment with a BIMS status) as 15/15. Resymptoms of delirium affecting others. Resident #25's curre was reviewed. The country weight fluctuation were in part to monitor. The April 2019 physic weights report weight Doctor." | te clinical record for 1 of 18 (25). It: It: It: It: It: It: It: It | F | 842 | | |
| | Dai tojoi totiowe | on the replination of the same | No 100 27 | | | |

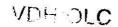
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VAD105

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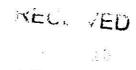
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A BUILDING | CONSTRUCTION | | (X3) DATE SURVEY COMPLETED C | |
|---|---|---|---|---|------------|------------------------------|--|
| | | 495323 | 8. WING | | 04/25/2019 | | |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS | | | STREET ADDRESS, CITY, STATE, ZIP CODE 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFIC | Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 842 | Continued From (| page 28 | F 842 | | | | |
| | weights. Resident #25 gained from 131.7 pounds on 4/11/19 to 139.7 pounds on 4/12/19-a difference of 8 pounds. The surveyor found no documentation of the weight change reported to the physician in the departmental notes for 4/12/19. There was a note dated 4/12/19 at 5:28 p.m. that the resident was seen by the nurse practitioner on that day with medication changes for anemia but for diuresis. Resident #25 gained from 130.2 pounds on 4/14/19 to 138.9 pounds on 4/15/19-a difference of 7.7 pounds. The surveyor found no documentation that the physician was made aware of the weight gain. The MD was made aware of that day's laboratory results but there was no documentation about the resident's weight gain as per the physician's orders. | | | | | | |
| | 4/18/19 to 139.8 of 7.7 pounds. The resident was to increase Lasix (every morning). Resident #25 ga on 4/20/19 to 13 difference of 7 produmentation in physician had be Resident #25gai 4/22/19 to 140.3 of 8.4 pounds. Fin | ined from 132.1 pounds on pounds on 4/19/19 - a difference the 4/19/19 1:37 p.m. note stated seen on rounds and a new order at to 60 mg (milligrams) q am sined weight from 132.1 pounds 9.1 pounds on 4/21/19-a pounds. There was no in the departmental notes that the seen informed of the weight gain. In the departmental notes that the seen informed of the weight gain. In the departmental notes that the seen informed of the weight gain. In the departmental notes that the seen informed of the weight gain. In the departmental notes that the seen informed of the weight gain. In the departmental notes that the seen informed of the weight gain. In the departmental notes that the seen informed the difference and changes to the diuretic seen and changes to the diuretic seen and changes to the diuretic seen and the administrator, the | | | | | |

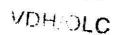
FORM CMS-2557(02-99) Previous Versions Obsolete

Event ID: XQ8811

Facility ID: VA0105

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | C 04/25/2019 | |
|--|---|---|---|--|-----------------------------|----------------------------|
| | | 495323 | | | | |
| NAME OF PROVIDER OR SUPPLIER HERITAGE HALL - LAUREL MEADOWS | | | | STREET ADDRESS, CITY, STATE, ZIP COL 16600 DANVILLE PIKE LAUREL FORK, VA 24352 | | 12312013 |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | | N SHOULD BE EAPPROPRIATE | (XS) COMPLETION DATE |
| F 842 | F 842 Continued From page 29 interim director of nursing, the minimum data set coordinator and the corporate registered nurse of the above concern with failure to document/notify the physician of weight changes on 4/25/19 at 12:51 p.m. No further information was provided prior to the exit conference on 4/25/19. | | F | 342 | | |
| | | | | | | |

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

Event ID: XQ8811

Facility ID: VA0105

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