FORM APPROVED

PRINTED: 08/19/2019

DEPARTMENT OF HEALTH AND HUMAN SERVICES

113 TOT WEDICALE	A MEDICAID SERVICES	_===			<u> DMB NO. 0938-0391</u>
T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	150 72570		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	B. WING			C 08/08/2019
PROVIDER OR SUPPLIER GE HALL NASSAWAD	ох		9468	HOSPITAL ROAD	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL		х	(EACH CORRECTIVE ACTION SHOUL	DBE COMPLETION
Initial Comments		E	000		
survey was conduct 08/08/19. The facil compliance with 42 Requirement for Lo emergency prepare investigated during	ted 08/04/19 through ity was in substantial CFR Part 483.73, ng-Term Care Facilities. No edness complaints were the survey.	FC	000		Ti di
survey was conductextended survey was Corrections are requirements. Three investigated during	ted 8/4/19 through 8/8/19. An as conducted on 8/6/19. uired for compliance with 42 and Long Term Care complaints were survey. The Life Safety Code				
134 at the time of the survey sample constreviews and 8 closes Respect, Dignity/Rig	ne survey. The standard sisted of 48 current resident ed record reviews. ght to have Prsnl Property	F 5	557	Deed	
The resident has a and dignity, including	right to be treated with respecting:			Corrective Action(s): Resident #124 is now draped in the appropriate fashion to prevent body exposure during the provision of car	e and were ignity care
possessions, included as space permits, use upon the rights or horesidents. This REQUIREMENT by:	ling furnishings, and clothing, unless to do so would infringe health and safety of other			inserviced on maintaining resident d and privacy during the provision of and treatment. This includes proper precautions to prevent body exposur during care. A facility Incident &	e
	PROVIDER OR SUPPLIER SE HALL NASSAWAD SUMMARY STA (EACH DEFICIENCY REGULATORY OR L. Initial Comments An unannounced E survey was conduc 08/08/19. The facil compliance with 42 Requirement for Lo emergency prepare investigated during INITIAL COMMENT An unannounced I survey was conduc extended survey was Corrections are req CFR Part 483 Fede requirements. Thre investigated during survey/report will fo The census in this 134 at the time of th survey sample cons reviews and 8 close Respect, Dignity/Ri CFR(s): 483.10(e)(s) §483.10(e) Respect The resident has a and dignity, includir §483.10(e)(2) The i possessions, includ as space permits, i upon the rights or h residents. This REQUIREMENT by:	TOF DEFICIENCIES DEFICIENCIES IDENTIFICATION NUMBER: 495277 PROVIDER OR SUPPLIER GE HALL NASSAWADOX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments An unannounced Emergency Preparedness survey was conducted 08/04/19 through 08/08/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/4/19 through 8/8/19. An extended survey was conducted on 8/6/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during survey. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 134 at the time of the survey. The standard survey sample consisted of 48 current resident reviews and 8 closed record reviews. Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced	PROVIDER OR SUPPLIER SE HALL NASSAWADOX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments An unannounced Emergency Preparedness survey was conducted 08/04/19 through 08/08/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 8/4/19 through 8/8/19. An extended survey was conducted on 8/6/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during survey. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 134 at the time of the survey. The standard survey sample consisted of 48 current resident reviews and 8 closed record reviews. Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by:	TOP DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495277 495277 B. WING STRE SE HALL NASSAWADOX SEHALL NASSAWADOX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments An unannounced Emergency Preparedness survey was conducted 08/04/19 through 08/08/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 8/4/19 through 8/8/19. An extended survey was conducted 8/4/19 through 8/8/19. An extended survey was conducted on 8/6/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during survey. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 134 at the time of the survey. The standard survey sample consisted of 48 current resident reviews and 8 closed record reviews. Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) \$483.10(e) (Respect and Dignity. The resident has a right to be treated with respect and dignity, including: \$483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by:	A BUILDING ASSAWADOX STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413 SE HALL NASSAWADOX STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413 PROVIDERS PLAN OF CORRECTIVE (EACH DERICLENCY MUST SE PRECEIBED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) Initial Comments An unannounced Emergency Preparedness survey was conducted 06/04/19 through 09/08/19. The facility was in substantial compliance with 42 CFR Part 483,73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. INITIAL COMMENTS F 000 An unannounced Medicare/Medicaid standard survey was conducted 8/4/19 through 8/8/19. An extended survey was conducted on 8/6/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Three complaints were investigated during survey. The Life Safety Code survey/report will follow. The census in this 145 certified bed facility was 134 at the time of the survey. The standard survey was not 8 closed record reviews. Respect, Dignity/Right to have Prsnl Property CFR(s): 483.10(e)(2) \$483.10(e) (2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This RICLUS personal for the incident. This RICQUIREMENT is not met as evidenced by: **Corrective Action(s): Resident #124 is now draped in the appropriate fashion to prevent body exposure during the provision of car treatment. L.P. N. 9 and C.N. N. 18. 18. 18. 18. 18. 18. 18. 18. 18. 18

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 astructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

RECEIVED

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	5 S 1252	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495277	B. WING _		700000 00	C 08/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 557	facility staff failed to exposure of body during the provision in the survey samp. The findings include Resident #124 wa 9/20/18 with diagn to, stroke and diab (Minimum Data Seassessment refere the resident as hamemory deficits. assistance of two dependent for transconditions the resistage IV pressure as-full thickness titendon, or muscle present on some present on some providing assistance of two dependent for transconditions the resistage IV pressure as-full thickness titendon, or muscle present on some providing at 12:33 sacral dressing chacility wound nurse. Nurse-LPN #9) providing assistant on her side. Upon the resident was it side and complete had just provided. The curtains were the B bed side, the room at the time, a During the dressir "my hiney"the C	facility document review the oprovide draping to prevent parts and maintain dignity in of care for 1 of 56 residents ple, Resident #124.		Identification of Deficient Corrective Action(s): All other residents receiving may have potentially been a DON, ADON and/or unit meconduct 100% audit of all receiving wound care to ide at risk. Any/all negative finidentified will be corrected discovery. An Incident and will be completed for each finding. Systemic Change(s): The facility policy and proceed been reviewed and no changat this time. All nursing statinserviced by the DON and services director on maintaidignity and privacy during of care and treatment. To in maintaining dignity and privacy during unnecessary body parts. Monitoring: The wound Care Nurse is maintaining compliance. Dunit Managers will compleweekly treatment audits to compliance. Any negative corrective at time of discoved disciplinary action will be trequired. Aggregate finding reported to the QA Commit analysis, and recommendatin facility policy, procedure Completion Date: 9/20/19	g wound care affected. The nanagers will esidents entify residents dings at the time of Accident form negative edure has ges warranted ff will be lor social ining resident the provision nelude ivacy during exposure of expo	

PRINTED: 08/19/2019 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			
		and the state of t	A. DUILL	A. BOLEBING		С		
		495277	B. WING			08/	08/08/2019	
	PROVIDER OR SUPPLIER	ox		9468	EET ADDRESS, CITY, STATE, ZIP CODE B HOSPITAL ROAD SSAWADOX, VA 23413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	Source 1	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 557	men." The resident course of the dress approximately 20 no change, CNA #6 wasked why the residraping/covering to parts during the dresstated, "I wasn't this of the resident not the dressing changenurse. The wound a gown onshe she covering her," whe "Dignity." 8/8/19 at 12:48 p.m eating lunch in bedokay if I asked her "I hope I can answ asked how she felt	or and the resident stated, "no tremained naked during the sing change which lasted ninutes. After the dressing as interviewed. She was dent was not provided prevent exposure of body essing change. The CNA nking." a.m., the observation concernate being provided draping during the was shared with the wound nurse stated "She usually has ould have had a sheet in asked why she stated, a., the resident was observed to she was asked if it would be a question, her response was, the it." The resident was then to being left completely naked the dressing change, she stated,	F	557				
	meeting the above Administrator and The DON stated, "	o.m., during the pre-exit findings was shared with the the Director of Nursing (DON). I definitely don't think that is a she should have have taken a the resident."						
	revised August 20 Policy Statement-E in a manner that p of life, dignity, resp	itled Quality of Life-Dignity I 6 read, in part: Each resident shall be cared for romotes and enhances quality sect and individuality. On and Implementation:						

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 3 of 79

RECEIVED

AUG 30 2019

VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495277	B. WING		C 08/08/2019	
NAME OF F	PROVIDER OR SUPPLIER	-	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LICOITAC	TE HALL MACCANIAN	OV	9	468 HOSPITAL ROAD		
DERITAC	E HALL NASSAWAD	OX.	N	IASSAWADOX, VA 23413		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 557 Continued From page 3		' F 557		g 1		
	10. Staff shall prom resident privacy, inc the assistance with treatment procedur	note, maintain and protect cluding bodily privacy during personal care and during	F 584			
	S483.10(i) Safe Engineer The resident has a comfortable and he but not limited to resupports for daily limited to receive environm use his or her persuppossible. (i) This includes entreceive care and sephysical layout of the independence and (ii) The facility shall	vironment. right to a safe, clean, smelike environment, including ceiving treatment and ving safely. ovide- e, clean, comfortable, and ent, allowing the resident to onal belongings to the extent suring that the resident can ervices safely and that the ne facility maximizes resident does not pose a safety risk. exercise reasonable care for	F 584	F584 Corrective Action(s): Resident #78's Broda Chair has breplaced. A facility Incident and form was completed for this incid	Accident	
	or theft. §483.10(i)(2) House services necessary and comfortable into \$483.10(i)(3) Clean in good condition; §483.10(i)(4) Privat resident room, as s	ekeeping and maintenance to maintain a sanitary, orderly,				

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PRAND PLAN OF CORRECTION ID		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	76-11/20-11/20-11/20	(X2) MULTIPLE CONSTRUCTION A. BUILDING		OATE SURVEY COMPLETED
		495277	B. WING	5500 Major M		C 08/08/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00/00/2019
HEDITAC	SE HALL NASSAWAD	ov		9468 HOSPITAL ROAD		
DENITAG	IE HALL NASSAWAD	OX.		NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 584	levels. Facilities init 1990 must maintain 81°F; and §483.10(i)(7) For th sound levels. This REQUIREMEN by: Based on observat record review the fa medical equipment for 1 of 56 residents Resident #78. Res observed to have a and a piece of the f The findings include Resident #78 was a 2/20/14 with diagno to, seizures, trauma hemiplegia (Spastion neuromuscular con in the muscles on o constant state of co side. The current for quarterly with an as 6/11/19 coded the r a 15 on the BIMS (I Status), indicating to impaired cognition. extensive assistant and transfers. The Based on the Resid for the prevention of	ortable and safe temperature ially certified after October 1, a a temperature range of 71 to be maintenance of comfortable of the maintenance of the maintenance of comfortable of the survive of the maintenance of	F 5	Identification of Deficient and Corrective Action(s): All other resident wheelchair potentially been affected. A documented environmental reacility wheelchairs will be the administrator, and/or Ma Director to identify any reside wheelchairs in need of clean repair/replaced. All resident identified as needed repairs of will be corrected at time of da facility Incident and Accid be completed for each negation of the facility's policy & proce providing a safe, sanitary, and comfortable environment has reviewed. No changes are within time. The Maintenance I and/or Environmental Direct provide inservices to all staff policy and procedure on the system to use when cleaning repairs are needed to facility equipment throughout the fact throughout the fact in the Administrator and Main Director are responsible for a compliance. Documented when rounds will be completed we monitor compliance. The administrator and the censure negative findings a corrected. Cumulative findin reported to the Quality Assur Committee for review, analy, recommendations for change policy, procedure, and/or pra Completion Date: 9/20/19	rs may have complete eview of all conducted by intenance lent ing and/or wheelchairs or replaced iscovery and ent form will ve finding. I dure for d is been arranted at Director or will fon facility notification and/or and resident cility. I tenance maintaining leelchair ekly to ministrator lidits weekly to being gs will be rance sis, and in facility	

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

Event ID:W1Y811

Facility ID: VA0116

If continuation sheet Page 5 of 79

RECEIVED

PRINTED: 08/19/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING ____ C 495277 B WING 08/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD HERITAGE HALL NASSAWADOX NASSAWADOX, VA 23413 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION. TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 584 | Continued From page 5 F 584 mobile chair). On the initial tour of the right side unit on 8/4/19 and at 4:29 p.m., the resident was observed sitting up in the Broda chair at the bedside. The chair was observed as follows: the left side vinyl panel was ripped and torn, the right adjustable wing for upper lateral support had multiple cracked areas in the vinyl located in proximity of where the resident face can make contact, and the right black foam arm rest was missing a piece that had been torn/ripped off measuring approximately 1.5 inches by 2 inches. The resident was observed sitting in the Broda chair each of the following days of the survey 8/5/19, 8/6/19 and 8/7/19, the Broda chair remained in the same condition. On 8/7/19 at 10:55 a.m., the right side unit

getting a new chair."

manager was interviewed. She was asked about Resident #78's Broda chair in need of repair. She stated she was not made aware of it. She stated if medical equipment needs repair the request is placed into the maintenance computer system named TELS or sent to the therapy department depending on what is needed, she stated, "I can't always get into that system (TELS), so then I just tell them (maintenance)." She was asked to accompany this surveyor to the resident's room to look at the Broda chair. After noting the areas she stated to the resident, "Looks like you'll be

On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing. The Administrator stated, "...we do have additional Broda chairs." She stated she would have

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER SE HALL NASSAWAD	ox		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	1 00/00/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	^{60.7}	D BE COMPLETION
F 607 SS=D	survey team prior to Develop/Implement CFR(s): 483.12(b)(§483.12(b) The fact implement written progression of \$483.12(b)(1) Prohogological metalogical metalogica	nation was provided to the o exit. Abuse/Neglect Policies 1)-(3) illity must develop and policies and procedures that: ibit and prevent abuse, tation of residents and resident property, blish policies and procedures tuch allegations, and de training as required at procedures are allegations, and it is not met as evidenced that the facility record from an abuse policy to include the ence screening for one (1) are out of 25 records reviewed. The electron of reference and outled for a current the facility failed to record the electron of the ence of the electron of	F 6	F607 Corrective Action(s): C.N. A. #9 has had their reference forms reviewed by the HR director references have been obtained. A F Incident & Accident form has been completed for this incident. Identification of Deficient Practic Corrective Action(s): All other employees may have been potentially affected. The Human Resources department will audit 10 all active employee records to iden employees at risk. Any/all negative findings will be corrected at the time discovery. A Facility Incident and Accident Report will be completed any/all negative findings.	and all facility ces & n 00% of tify the of

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

Event ID; W1Y811

Facility ID: VA0116

If continuation sheet Page 7 of 79

RECEIVED

AUG 30 2019

VDH/OLC

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C
		495277	D. WING		08/08/2019
NAME OF F	PROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAG	E HALL NASSAWAD	ΩY		9468 HOSPITAL ROAD	
HERITAC	IL HALL NASSANAD			NASSAWADOX, VA 23413	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENCY	YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI) TAG		BE COMPLÉTION
F 607	Continued From pa	ine 7	F 6	Systemic Change(s):	
1 007	Commueu From pa	ige /	F 6	The facility policy and procedure has	s
				been reviewed and no changes are	
		ouse Prevention Program		warranted at this time. Administrativ	
	documented in part	t, the following:		Staff, Department Managers and the	HR
				department will be inserviced on the	8
	"2. Conduct empl	oyee background checks and		policy & procedure regarding abuse	
	will not knowingly e	mploy or otherwise engage		prevention and pre-employment	
	any individual who	has:	į	procedures by the Administrator.	
	a. Have been foun	d guilty of abuse, neglect,		Administrative Staff and Department	:
	exploitation, misap	propriation of property, or		Heads extending employment without meeting the requirements of the facil	lt
	mistreatment by a	court of law;		policy & procedure will receive	ıt y
		ing entered into the State	ES	disciplinary action. Perspective	
		concerning abuse, neglect,	16	employees will not be allowed to wo	rk
		atment of residents or		until all required documentation has	been
	misappropriation of			obtained and reviewed by the approp	riate
		ary action in effect against his	M ex	department manager.	
		license by a state licensure		30.00	
		a finding of abuse, neglect, or		Monitoring:	
		atment of residents or		The Human Resources Manager is	
	misappropriation of			responsible for maintaining complian	.ce.
ı,		realization property.		The Human Resources Director and/o	or i
	Facility policy did no	ot incorporate procedures for		designee will conduct monthly audits all new hire employee files for each	of
		vee reference checks.		month to maintain compliance. The	1
E 622	Transfer and Disch		F 6		, I
	CFR(s): 483.15(c)(10	report aggregate findings to the Quali	tv
55=E	OTTI(3). 403.13(6)(·/(//(")(~)(")	24.00	Assurance Committee for review.	9
	§483.15(c) Transfe	r and discharge		analysis, and recommendations for	
	§483.15(c)(1) Facil			changes in policy, procedure, and/or	5/2
				facility practice.	Ĭ
		permit each resident to		Completion Date: 9/20/19	
		y, and not transfer or		[] [6]	
		ent from the facility unless-		F622	
		discharge is necessary for the		Corrective Action(s):	
		and the resident's needs	j	The facility staff failed to ensure the	
	cannot be met in th			comprehensive care plan goals were	
		discharge is appropriate		submitted to the receiving hospital for	1
		nt's health has improved		Residents #101 on 1/18/19, 3/25/19,	
		esident no longer needs the		7/18/19 and 7/21/19 when transferred	to !
	services provided b			the hospital. A facility Incident &	_
	(C) The safety of in	dividuals in the facility is		Accident Form has been completed for these incidents.	τ
			[mess meldelles.	

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495277	B. WING		C 08/08/2010
	PROVIDER OR SUPPLIER GE HALL NASSAWAD SUMMARY STA	OX TEMENT OF DEFICIENCIES	94	REET ADDRESS, CITY, STATE, ZIP CODE 168 HOSPITAL ROAD ASSAWADOX, VA 23413 PROVIDER'S PLAN OF CORRECTIO	08/08/2019
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLÉTION
F 622	endangered due to status of the reside (D) The health of in otherwise be endar (E) The resident ha appropriate notice, under Medicare or Nonpayment applie submit the necessary payment or after the Medicare or Medicare or Medicare or Medicare or Medicare or Medicare ident refuses to resident who become admission to a facility resident only allowed or (F) The facility may resident while the as \$431.230 of this charge notice from 431.220(a)(3) of this discharge or transfor safety of the resident under any in paragraphs (c)(1) section, the facility or discharge is documedical record and communicated to the institution or provides.	the clinical or behavioral nt; dividuals in the facility would igered; s failed, after reasonable and to pay for (or to have paid Medicaid) a stay at the facility. s if the resident does not any paperwork for third party e third party, including aid, denies the claim and the pay for his or her stay. For a nes eligible for Medicaid after ity, the facility may charge a able charges under Medicaid; ses to operate. not transfer or discharge the ppeal is pending, pursuant to apter, when a resident right to appeal a transfer or om the facility pursuant to § s chapter, unless the failure to er would endanger the health dent or other individuals in the must document the danger er or discharge would pose. Immentation. Cansfers or discharges a of the circumstances specified (i)(i)(A) through (F) of this must ensure that the transfer umented in the resident's appropriate information is ne receiving health care	F 622	The facility staff failed to ensure the comprehensive care plan goals were submitted to the receiving hospital for Residents #61 on 2/11/19 when transferred to the hospital. A facility Incident & Accident Form has been completed for these incidents. The facility staff failed to provide the receiving Hospital with contact information for the attending physicic contact information for the Resident Representative, Advance directive information, or comprehensive care proposed for Resident #128 on 6/1/19, 6/16/19, and 6/21/19. A facility incide and accident form has been complete this incident. Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have 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 with completed for each negative finding. Systemic Change(s): Facility policy and procedures have be reviewed. No revisions are warranted this time. The DON and/or Regional Nurse Consultant will inservice facilities the staff on the documentation required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospi other outside health care facility.	e an, plan lent ed for e d/or audit arged the did

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 9 of 79

RECEIVED

AUG 3 0 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED			
TOTO (LETT O					С	
		495277	49 1000 C ALL LINE OF A COL		08/0	08/2019
	PROVIDER OR SUPPLIER	ох	946	BEET ADDRESS, CITY, STATE, ZIP CODE 8 HOSPITAL ROAD SSAWADOX, VA 23413		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 622	(i) of this section. (B) In the case of psection, the specifible met, facility atteneeds, and the serfacility to meet the (ii) The documenta (2)(i) of this section (A) The resident's discharge is neces (A) or (B) of this sec (B) A physician whenecessary under postinis section. (iii) Information promust include a min (A) Contact information promust include a min (C) Advance Direction (C) Advance Direction (C) Advance Direction (C) All special instrongoing care, as a (E) Comprehensive (F) All other necessary other documer a safe and effective This REQUIREME by: Based on medical and facility documer failed to send the cupon transfer to the	ne transfer per paragraph (c)(1) raragraph (c)(1)(i)(A) of this c resident need(s) that cannot impts to meet the resident vice available at the receiving need(s). Ition required by paragraph (c) in must be made by- chysician when transfer or sary under paragraph (c) (1) inction; and ten transfer or discharge is taragraph (c)(1)(i)(C) or (D) of vided to the receiving provider imum of the following: tation of the practitioner care of the resident. sentative information including tive information functions or precautions for perpropriate. The care plan goals; The sary information, including a this discharge summary, The sary information, including a this discharge summary, The sary information, as applicable, and thation, as applicable, to ensure		Monitoring: The DON/designee will be responsible maintaining compliance. The DON and designee will conduct chart audits weel of all residents who have been discharg and/or transferred from the facility to monitor for compliance. Any/all negat findings and or errors will be corrected time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: 9/20/19	Mor kly ged ive at of	

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

AND BLAN OF CORRECTION DENTIFICATION NUMBER:		[2018.3909 P03/00234350]	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495277	B. WING		08/08/2019
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX			STREET ADDRESS, CITY, STATE, ZIP C 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	• • • • • • • • • • • • • • • • • • • •
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE COMPLÉTION
F 622	Continued From page	age 10	F	522	
	facility on 2/28/14 with diagnoses to in Functional Quadrip Disease. Resident #101's material (MDS) is a Quarter (ARD) of 6/20/19.	led: was originally admitted to the and was re-admitted on 7/30/19 nclude but not limited to olegia and End Stage Renal ost recent Minimum Data Set rly with an Assessment Date The Brief Interview for Mental a 15 out of a possible 15			
	which indicated the intact and capable Resident #101's D	at Resident #101 is cognitively of daily decision making. etail Discharge Report was mented in part, as follows: to Hospital.			
	documentation that goals were sent of 7/21/19 upon Resilinospital. On 8/8/19 at 11:30 conducted with the Resident #101's conducted sent upon Director of Nursing part of the Transfer computer and I care	eview indicated no at comprehensive care plan a 1/18/19, 3/25/19, 7/18/19, and dent #101's transfers to the A.M. an interview was be Director of Nursing regarding comprehensive care plan goals on transfer to the hospital. The ag stated, "The care plan is a ser Discharge Summary in the annot find documentation for a not aware that we had to			

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 11 of 79

RECEIVED

AUG 3 g 2019

VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200 ACCUSTO AC	FIPLE CONSTRUCTION NG _	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCE	ON SHOULD BE COMPLETION THE APPROPRIATE DATE
F 622	document that the when we send a recommend that the when we send a recommend to the when we send a recommend to the with the Administration where the above in exit no further information of the current of the current of the current of the disorder. The current of the current	care plan goals were sent esident out." a pre-exit debriefing was held ator and the Director of Nursing aformation was shared. Prior to mation was provided. as admitted to the facility on mitted to the facility on es for Resident #61 included alzheimer's disease and anxiety The Data Set (MDS), was a ment with an Assessment RD) of 02/11/19. Staff intal status coded the resident in memory problems. S assessments was dated for ge return anticipated; facility on 02/14/19. Inding to the facility's MS (Emergency Medical e facility with (Resident #61) hospital."			

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	26 25	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C
	PROVIDER OR SUPPLIER		11 TO	STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	08/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	# PARTY	JLD BE COMPLETION
F 622	to send with the resident was cond and Director of Nurabove findings. The have been done? The send the care plant in the nurses noted as a Resident #128 with transform 6/1/2019, 6/16/2019, 6/16/2019, 6/16/2019, 6/16/2019, 6/16/2019, 6/16/2019. Resident #128's middle and set) assessment with a date of 7/9/19. Resident #128's middle as a set of 7/9/19, and 6/2019 at applicatives, or the cather resident at the 6/16/2019, and 6/2019 at applinterview was conditionally as a set of 8/8/2019 at applinterview was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applinterview was conditionally as a set of 8/8/2019 at applinterview was conditionally as a set of 8/8/2019 at applinterview was conditionally as a set of 8/8/2019 at applinterview was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at applicative was conditionally as a set of 8/8/2019 at	dures: Prepare a transfer form sident. Proximately 3:00 PM a pre-exit ucted with the Administrator sing they were informed of the ey were asked what should the DON commented, "We but we were not documenting e." Pass admitted to the facility on afters to the hospital occurring 1019 6/21/2019 and 7/21/2019. If, but not limited to, type 2 ith diabetic neuropathy, re, respiratory failure with thronic kidney disease, nic ischemic heart disease, creas, and morbid obesity. Post recent MDS (minimum ent was a 14 day scheduled in ARD (assessment reference sident #128 was coded as nitive function scoring 15 out of BIMS (brief interview for m. Pence that the required sysician contact information, advanced are plan goals were sent with time of transfer on 6/1/2019,		622	

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 13 of 79

RECEIVED

AUG 30 2019

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	19 10 10 10 10 10 10 10 10 10 10 10 10 10	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		405077	2 11/10		С
	44	495277	B. WiNG		08/08/2019
NAME OF	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
HEDITAC	SE HALL NASSAWAD	OY	946	8 HOSPITAL ROAD	
пепнас	SE HALL NASSAWAD		NA	SSAWADOX, VA 23413	
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 622	Continued From pa	ge 13	F 622		j
	of Nursing), reques of advanced directive care, care plan goal information, responsition a transfer summary occurred on 7/21/20. There was no additional by ASM #3. Additional conducted yielded referenced, require transfer to the hosp	ting evidence, upon transfer, ves, instructions for ongoing ls physician contact sible party information; yielded for a hospital transfer that	T GZZ		
		on Transfer or Discharge vised December 2016)			
	from the facility, the documented in the a. The basis for the (1) If the resident is discharged because met at the facility, d	nt is transferred or discharged of following information will be medical record: e transfer or discharge; is being transferred or e his or her needs cannot be ocumentation will include: dent needs that cannot be			
	(b) this facility's atte (c) the receiving face available to meet the b. That an appropring resident and/or legal c. The date and time d. The new location e. The mode of tra	iate notice was provided to the all representative; ne of the transfer or discharge; no of the resident; nsportation; e resident's overall medical, all condition; ersonal effects;			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Mile Same Common Management and Common Commo	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING	- N	C 08/08/2019
	PROVIDER OR SUPPLIER	ox	9.	TREET ADDRESS, CITY, STATE, ZIP CODE 468 HOSPITAL ROAD IASSAWADOX, VA 23413	1 00/00/2013
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 625	j. The signature of in the medical record in the medical record. 7. Should a resider for any reason, the communicated to tha. The basis for traction of the communicated to that are because met at the facility, do the specific resmet; (b) this facility's attend (c) the receiving fact available to meet the contact information of the contact in	priate or as necessary; and the person recording the data rd. In the transferred or discharged following information will be the receiving facility or provider: Insfer or discharge; is being transferred or his or her needs cannot be ocumentation will include: ident needs that cannot be empt to meet those needs; ident needs that cannot be empt to meet those needs; ident of the practitioner care of the resident; entative information including including information; ctions or precautions for oppopriate; care plan goals; and any information, including a test discharge summary, and testion, as applicable, to effective transition of care. Policy Before/Upon Trnsfr	F 625	F625 Corrective Action(s): Resident #101 and their RP have been not that the facility failed to review and offer of bed-hold when Resident #101was transto the hospital on 1/18/19, 3/25/19, 5/7/19 7/18/19, 7/21/19, and 7/26/19. An Incider	notice ferred), at and
	the resident goes o	n therapeutic leave, the t provide written information to		Accident form has been completed for thi resident.	S

PRINTED: 08/19/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING C B. WING 495277 08/08/2019 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 9468 HOSPITAL ROAD HERITAGE HALL NASSAWADOX NASSAWADOX, VA 23413 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION DATE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 625 Continued From page 15 F 625 Resident #61 and their RP have been notified the resident or resident representative that that the facility failed to review and offer notice specifiesof bed-hold when Resident #61 was transferred (i) The duration of the state bed-hold policy, if to the hospital on 2/11/19. An Incident and any, during which the resident is permitted to Accident form has been completed for this resident. return and resume residence in the nursing Resident #129 and their RP have been notified (ii) The reserve bed payment policy in the state that the facility failed to review and offer notice plan, under § 447.40 of this chapter, if any; of bed-hold when Resident #129 was transferred (iii) The nursing facility's policies regarding to the hospital on 7/28/19. An Incident and bed-hold periods, which must be consistent with Accident form has been completed for this paragraph (e)(1) of this section, permitting a resident. resident to return; and (iv) The information specified in paragraph (e)(1) Resident #128 and their RP have been notified that the facility failed to review and offer notice of this section. of bed-hold when Resident #128 was transferred to the hospital on 6/1/19, 6/16/19, 6/21/19, and §483.15(d)(2) Bed-hold notice upon transfer. At 7/21/19. An Incident and Accident form has the time of transfer of a resident for been completed for this resident. hospitalization or therapeutic leave, a nursing facility must provide to the resident and the Identification of Deficient Practice(s) and resident representative written notice which Corrective Action(s): specifies the duration of the bed-hold policy All other residents could potentially be affected. described in paragraph (d)(1) of this section. The Bed-Hold policy and forms are now kept at This REQUIREMENT is not met as evidenced the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions Based on medical record review, staff interviews, director will be responsible for normal business and facility document review the facility staff failed hour transfer notification of all bed-holds to to send Bed Hold Notices upon transfer to the residents and/or Responsible parties. hospital for 4 of 56 residents in the survey. sample, Residents #101, #61, #129 and #128. Systemic Change(s): The facility Policy and Procedure has been The findings included: reviewed and no changes are warranted at this time. The Social Services Director, Admissions 1. Resident #101 was originally admitted to the Director and licensed staff have been

Disease.

facility on 2/28/14 and was re-admitted on 7/30/19

with diagnoses to include but not limited to

Functional Quadriplegia and End Stage Renal

Resident #101's most recent Minimum Data Set

Hold policy.

inservicedby the administrator and/or Social Services director on the bed-hold requirement

and the proper use and notification of the Bed-

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			11. 50125			,	С	
		495277	B. WING		5	08/	08/2019	
	PROVIDER OR SUPPLIER GE HALL NASSAWAL			94	REET ADDRESS, CITY, STATE, ZIP CODE 168 HOSPITAL ROAD ASSAWADOX, VA 23413			
(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 SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 625	(MDS) is a Quarte (ARD) of 6/20/19. Status (BIMS) was which indicated the intact and capable Resident #101's D review and is docu 1/18/19 Discharge 3/25/19 Discharge 5/7/19 Discharge 7/21/19 Discharge 7/21/19 Discharge 7/26/19 Discharge 7/26/19 Discharge 7/26/19 Discharge 7/26/19 Upon Resi hospital. On 8/8/19 at 11:30 conducted with the Resident #101's B upon transfer to the 5/7/19 7/18/19, 7/2 Director of Nursing is in our green trarthe resident on dis we had to docume was sent when we On 8/7/19 at 3:00 with the Administration of the resident status of the resident was sent when we on 8/7/19 at 3:00 with the Administration of the resident status of the resident status of the resident on dis we had to docume was sent when we on 8/7/19 at 3:00 with the Administration of the resident status of	The Brief Interview for Mental a 15 out of a possible 15 at Resident #101 is cognitively of daily decision making. etail Discharge Report was mented in part, as follows: to Hospital. eview indicated no at Bed Hold Notices were sent 9, 5/7/19, 7/18/19, 7/21/19 and dent #101's transfers to the process of Nursing regarding to Hold Notices not being sent to hospital on 1/18/19, 3/25/19, 21/19 and 7/26/19. The grated, "Our Bed Hold Notice insfer packet that we sent with scharge. I was not aware that that the Bed Hold Notice is send a resident out."		525	Monitoring: The Admissions Director and Social Ser Director are responsible for compliance. transfers/discharges from the facility wil audited the by the Social service director. Admissions Director to ensure proper be notification was completed at the time of or therapeutic leave. Any/all negative fir 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, and practice. Completion Date: 9/20/19	All l be r and/or ed-hold f transfer ndings he to the for		
	exit no further info	nformation was shared. Prior to rmation was provided. as admitted to the facility on lmitted to the facility on						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 2/45 2	TIPLE CONSTRUCTION NG	(>		SURVEY PLETED
		495277	B. WING _			08/0) 08/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	DE .	00/0	1012013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD B	The second second	(X5) COMPLETION DATE
F 625	but not limited to, A Anxiety Disorder. The current Minimudischarged assessing Reference Date (Al assessment of mer as having short term. The Discharge MD: 02/11/19 - discharge re-admitted to the formal of the following of the following resulting the properties of the following of the followin	es for Resident #61 included Alzheimer's disease and um Data Set (MDS), was a ment with an Assessment RD) of 02/11/19. Staff Intal status coded the resident in memory problems. S assessments was dated for perturn anticipated; facility on 02/14/19. Proximately 3:00 PM a pre-exit functed with the Administrator raing they were informed of the rey were asked what should the DON commented, "We do notice, but we were not the nurses note." Pervices on 7/5/19 following a region a left hip fracture and 8/1/19 after a hospitalization poley related sepsis Urinary I), other diagnoses included of (a dysfunction of the bladder) of current MDS (Minimum Data an assessment reference date are resident as having long and deficits and severely impaired daily decision making. If ace sheet evidenced the sown responsible party. The attive was listed as a son.		25			
	The resident was se	ent out to the emergency room					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495277	B. WING _	28.8.0		C (08/2019	
	PROVIDER OR SUPPLIER	ох	eder HE	STREET ADDRESS, CITY, STATE, ZIP COD 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		A 200 A	
(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 CORRECTIVE ACTION SECONDS TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 625	condition on 7/28/1 re-admitted to the free-admitted to the factor of the written notice with the written notice with the time of trans. On 8/6/19 at 4:15 pright side unit were Practical Nurse/LP about the transfer pwritten notification. get the notice signet transferred and if it is soon as possible. They stated they do that it was provided that it was provided on 8/8/19 at 3:00 pmeeting with the AN Nursing the above stated that the bed do go with the residence of the provide extended to the provide ext	hospital for a change in 9. The resident was acility on 8/1/19. ence in the clinical record that thich describes the bed-hold of to the resident representative fer to the hospital on 7/28/19. J.m., the two nurses on the interviewed (Licensed N #7 & #8). They were asked process and bed hold policy LPN #8 stated they attempt to be deduced before the resident is ot the facility gets it signed as When asked about the policy not document in the record		25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA !DENTIFICATION NUMBER:	5.0000000000000000000000000000000000000	TPLE CONSTRUCTION NG	(E SURVEY PLETED
	20010	495277	B. WING				08/2019
	PROVIDER OR SUPPLIER	оох	T.	STREET ADDRESS, CITY, STATE, ZIP COE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413)E	1000	
(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 CORRI (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD E		(XS) COMPLETION DATE
F 625	pseudocyst of pand Resident #128's m data set) assessment with a date) of 7/9/19. Rebeing intact in cogr possible 15 on the mental status) examinated as a part of ace-to-face intervior Practical Nurse (LF bedholds were subsend the bedholds. On 8/8/2019 at appringuiry regarding dispedhold notification Assistant Director of ace-to-face intervior face-to-face intervior face-to-face intervior face-to-face intervior face-to-face intervior face-to-face intervior face-to-face intervior face-to-fa	creas, and morbid obesity. cost recent MDS (minimum ent was a 14 day scheduled in ARD (assessment reference sident #128 was coded as nitive function scoring 15 out of BIMS (brief interview for m. eximately 10:40 a.m. a ew conducted with Licensed PN) when asked when mitted, stated, "the nurses " croximately 3:35 p.m. upon ocumentary evidence of a to the receiving provider, the of Nursing (ADON) responded, e that bedhold notification is	F 6;	25			
	evidence that the rewas sent upon trans 6/1/2019, 6/16/201 Facility policy on Tr. Documentation (rev. 7. Should a reside for any reason, the communicated to the a. The basis for trait (1) If the resident in discharge because met at the facility, or	ews conducted yielded no equired bedhold information sfer to the hospital on 9, 6/21/2019 and 7/21/2019. ansfer or Discharge vised December 2016) states: In the transferred or discharged following information will be ne receiving facility or provider: ansfer or discharge; a being transferred or his or her needs cannot be locumentation will include: ident needs that cannot be			n.		

	OF DEFICIENCIES OF CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE			(X3) DATE SURVEY COMPLETED	
		495277	B. WING		1	C 08/2019
	PROVIDER OR SUPPLIER	ох	de social	STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFEMENT DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 625	met; (b) this facility's att and (c) the receiving fa available to meet the Contact information responsible for the Contact information d. Advance Directive. All special instructions on the comprehensive of the comprehensive of the recess copy of the resident any other document ensure a safe and of the facility policy on Be March 2017) states Policy Statement: If therapeutic leaves, representatives will be dehold and return. 3. Prior to a transfegiven to the resident representatives that a. The rights and litergarding bed-holds b. The reserve bed by the state plan (nother hold a bed beyond to (Medicaid residents d. The details of the Transfer).	empt to meet those needs; cility's service(s) that are lose needs. tion of the practitioner care of the resident; entative information including type information; ctions or precautions for opropriate; care plan goals; and ary information, including a ts discharge summary, and tation, as applicable, to effective transition of care. ed-Holds and Returns (revised): Prior to transfers and residents or resident be informed in writing of the policy. er written information will be ats and the resident the explains in detail; mitations of the residents; payment policy as indicated on-Medicaid residents), or to the state bed-hold period	F 628			
	a. n.j / looooomone a	Leadi Every o Monthia	1 030	• •	Š	į

	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	166 26	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	ox		STREET ADDRESS. CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	1 00/00/2013
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	A facility must assequarterly review instand approved by Conce every 3 mont? This REQUIREMED by: Based on resident and facility docume to ensure that a Quwas submitted no limonths for 3 of 56 sample, (Residents The findings included 1. Resident #2 was diagnoses to included Diabetes Mellitus at Upon completing the is was noted that Parameter than 120 data Resident #2's most (MDS) was a Quar Reference Date (A Interview for Mentangossible 15 indication moderately cognitive some daily decision Assessment Admir (Registered Nurse)	ly Review Assessment ss a resident using the strument specified by the State MS not less frequently than ins. NT is not met as evidenced record review, staff interviews ent review the facility staff failed starterly Review Assessment ess than once every three residents in the survey is #2, #3 and #4). ed: s admitted on 10/12/18 with the but not limited to Type II and Cerebrovascular Disease. The Resident Assessment Task desident #2 was triggered for a (an assessment tool) that was	F 6	F638 Corrective Action(s): A facility Incident and Accident form been completed for Residents #2, #3 for completing and transmitting a quarterly MDS assessment late. Resi #2, #3 & #4 have had their comprehe care plan revised to reflect resident specific approaches and interventions address their specific needs. Identification of Deficient Practice Corrective Action(s): All other residents may have potential been affected. A 100% review of resident assessments will be done by the RCC and/or designee to ensure that all residenting a quarterly MDS have had completed in the last 92 days or transmitted late. Any/all negative fin will be reported to the resident care coordinator at time of discovery for immediate correction. Comprehensive care plans will be revised as needed reflect resident specific measurable objectives and interventions. Systemic Change(s): The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The RCC has inserviced by the Regional Nurse Consultant on scheduling and complem MDS assessments per the Resident Assessment Instrument (RAI) manual guidelines.	& #4 dent ensive s to and ally sident dents one dings been eting

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

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495277	B. WING			C / 08/2019	
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	юх	9	TREET ADDRESS, CITY, STATE, ZIP CODE 468 HOSPITAL ROAD IASSAWADOX, VA 23413		00/2013	
(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 CORRECT (EACH CORRECTIVE ACTION SHOTT CROSS-REFERENCED TO THE APPLICATION OF THE APPLICAT	OULD BE	(X5) COMPLETION DATE	
F 638	The CMS (Center of Submission Report Final Validation Re Quarterly MDS with reviewed and is do Submission Date/T P.M.) Accepted: Name: (Resident # Target Date: 6/25/Warning: Assessment company after A2300 (a The last Quarterly was on 3/18/19, who quarterly assessment Resident #2. On 8/7/19 at 1:33 From conducted with the Resident #2's Quasubmitted greater of Coordinator stated (Resident #2's) quasubmitted late. We department and since been trying to cate was also asked hoshould be submitted and submitted acceptable acceptable and submitted acceptable acceptab	for Medicare Services) It MDS 3.0 NH (Nursing Home) port for Resident #2's In the ARD of 6/11/19 was cumented in part, as follows: Time: 8/1/2019 15:50:08 (3:05 2) 19 Inent Completed Late: Detion date) is more than 14 assessment reference date). assessment submitted to CMS inch is over 4 months between ents being completed for P.M. an interview was MDS Coordinator regarding rerly assessments being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months being than 3 months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months between the months apart. The MDS Inch is over 4 months apart. The MDS	F 638	Monitoring: The RCC is responsible for compliance RCC and/or designee weekly audits coinciding with the MDS cato monitor for timely completion of assessments per the RAI guideline. Any/all negative findings will be reto the DON and the RCC will mak corrections at the time of discovery. Aggregate findings of the audits were ported to the Quality Assurance. Committee for review, analysis, an recommendations for change in fax policy, procedure, and/or practice. Completion Date: 9/20/19	MDS llendar f MDS s. eported e /. ill be		

Event ID: W1Y811

Facility ID: VA0116

RECEIVED

If continuation sheet Page 23 of 79

AUG 30 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495277	B. WING			C	
	PROVIDER OR SUPPLIER	oox		STREET ADDRESS, CITY, STATE, ZIP 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	CODE	08/08/2019	
(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 C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD HE APPROPE	BE COMPLETION	
	have difficulty with for the MDS's be betime." On 8/7/19 at 3:00 a with the Administra where the above in exit no further infor. Resident #3 was diagnoses to include and Anxiety Disord. Upon completing the is was noted that R. Minimum Data Set days late. Resident #3's most (MDS) was a Quart Reference Date (All Interview for Menta Resident #3 has lor deficits and was see daily decision making Assessment Admin (Registered Nurse) Verifying Assessment Report Final Validation Report Final Validation Report Final Validation Date/Tilescont Page 100	come new MDS staff and the time management. I expect e current and submitted on a pre-exit debriefing was held tor and the Director of Nursing formation was shared. Prior to mation was provided.	F 6	38			
	P.M.)	me: 8/2/2019 17:32:12 (5:32					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		495277	B. WING	<u> </u>		C /08/2019
	PROVIDER OR SUPPLIER	pox	946	REET ADDRESS, CITY, STATE, ZIP COD 8 HOSPITAL ROAD SSAWADOX, VA 23413		
(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 CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 638	(assessment complete days after A2300 (The last Quarterly was on 3/8/19, who quarterly assessment assessment at 1:33 conducted with the Resident #3's Quasubmitted greater Coordinator stated (Resident #3's) quasubmitted late. Would be submitted and submitted as also asked he should be submitted and submitted and submitted ac Assessment Instruction 8/8/19 at 2:13 conducted with the Resident #3's late Administrator state because we have have difficulty with for the MDS's be latime."	rent Completed Late: bletion date) is more than 14 assessment reference date). assessment submitted to CMS ich is over 4 months between ents being completed for P.M. an interview was a MDS Coordinator regarding than 3 months apart. The MDS I, "We just submitted his arterly MDS on 8/2/19, it was a have been short in the MDS nce I got here in June we have the up." The MDS Coordinator ow often quarterly assessment and for residents. The MDS I, "MDS's should be completed cording to the RAI (Resident ument) Manual." P.M. an interview was a Administrator regarding quarterly MDS. The ed, "I feel our MDS's were late some new MDS staff and the intime management. I expect the current and submitted on a pre-exit debriefing was held				
	with the Administr	ator and the Director of Nursing				

	T OF DEFICIENCIES OF CORRECTION			X3) DATE SURVEY COMPLETED		
		495277	B. WING _			C 08/08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	юх		STREET ADDRESS, CITY, STATE, ZIP 6 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	CODE	0000000
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B E APPROPAL	
F 638	Continued From pa exit no further inform	age 25 mation was provided.	F 63	8		
	4/11/16 with diagno to Type II Diabetes Upon completing the is was noted that Redinguish Minimum Data Set adays late. Resident #4's most (MDS) was a Quart Reference Date (AF Interview for Mental Resident #4 has lored deficits and was set adaily decision making (Registered Nurse)	admitted to the facility on oses to include but not limited Mellitus and Hypertension. The Resident Assessment Task resident #4 was triggered for a that was greater than 120 The recent Minimum Data Set terly with an Assessment RD) of 6/11/19. The Brief I Status indicated that the grand short term memory verely cognitively impaired for the ing. Under Section Z distration: Signature of RN Assessment Coordinator ent Completion was signed on				
	Submission Report Final Validation Rep Quarterly MDS with	or Medicare Services) MDS 3.0 NH (Nursing Home) port for Resident #4's the ARD of 6/11/19 was cumented in part, as follows:		N.		
	P.M.) Accepted: Name: (Resident #4 Target Date: 6/11/1 Warning: Assessment complete:					

STATEMENT OF DEFICIENCIES () AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 08/08/2019	
		495277					
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX				STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		700/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I - I - I - I - I - I - I - I - I - I -	SHOULD BE	(X5) COMPLETION DATE	
F 638	The last Quarterly was on 3/28/19, who quarterly assessment Resident #4. On 8/7/19 at 1:33 From Conducted with the Resident #4's Quasubmitted greater to Coordinator stated (Resident #4's) quasubmitted late. We department and since been trying to catch was also asked hoshould be submitted Coordinator stated and submitted acceptants and submitted acceptants. On 8/8/19 at 2:13 From Conducted with the Resident #4's late Administrator state because we have shave difficulty with for the MDS's be butime." The facility Policy to Instrument and is do Policy Interpretation 1. The Assessment for ensuring that the Team conduct times and the second of the second	assessment submitted to CMS nich is over 4 months between ents being completed for P.M. an interview was MDS Coordinator regarding therly assessments being than 3 months apart. The MDS than 3 months apart. The MDS was a have been short in the MDS arterly MDS today, it was a have been short in the MDS are I got here in June we have the up." The MDS Coordinator wo often quarterly assessment and for residents. The MDS wording to the RAI (Resident ment) Manual." P.M. an interview was Administrator regarding quarterly MDS. The downward of the time management. I expect the corner of the course of the	F	538			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495277			THE RESIDENCE THE PROPERTY OF	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		B. WING		C 08/08/2019		
	PROVIDER OR SUPPLIER GE HALL NASSAWAD		94	TREET ADDRESS, CITY, STATE, ZIP CODE 468 HOSPITAL ROAD IASSAWADOX, VA 23413	1	12010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE C	(X5) COMPLETION DATE
F 638	Continued From pa	age 27	F 638			
	held with the Admir Nursing where the Prior to exit no furth Accuracy of Assess CFR(s): 483.20(g) §483.20(g) Accuracy The assessment more resident's status. This REQUIREMED by: Based on staff intered and facility document to ensure an MDS assessment tool) were residents in the sure Section E. Behavior quarterly MDS with date of 7/10/19. The findings included Resident #121 was 11/6/12 with diagnoto, unspecified demonstrated demonstrates and facility demonstrates with severe psychial to the current MDS (Now ith an assessment coded the resident memory deficits and decision making skerolder in the current making skerolder in the cur	cy of Assessments. nust accurately reflect the NT is not met as evidenced erview, clinical record review ent review the facility staff failed (Minimum Data Set-an vas accurate for 1 of 56 rvey sample, Resident #121. ers was not accurate for the an assessment reference e: admitted to the facility on eses to include but not limited mentia without behavioral depressive disorder, recurrent	F 641	F641 Corrective Action(s): Resident #121 has had their most rece MDS modified to accurately code see E, Behaviors, Resident #121's comprehensive care plan has been reviewed and revised to include currer behaviors being exhibited. A facility Incident & Accident form was completed for this incident. Identification of Deficient Practice(s and Corrective Action(s): All other residents may have potential been affected. A 100% audit of all residents current MDS assessments whose completed by the RCC and/or design to ensure that sections E of the MDS acoded correctly. All negative findings be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancidentified on the most current MDS. Systemic Change(s): The Resident Interdisciplinary Care Thas been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections at the MDS. All comprehensive MDS's a quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data.	nt eted s) lly ill gnee are will or y eam	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DA	(X3) DATE SURVEY COMPLETED	
		495277	B. WING	i			C /08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	юх		946	REET ADDRESS, CITY, STATE, ZIP CODE 88 HOSPITAL ROAD SSAWADOX, VA 23413	_ 00	100/2019
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 641	required extensive toileting needs and dependent for bath Review of the Med for July 2019 evide administered Ativa PRN (as needed) for behaviors that were MDS: July 9th at 9:08 a.m. grabbing July 10th at 9:43 a.m. grabbing Review of the quare Assessment Admin Worker's signature C, D, E and Q. Se that the accompanied reflects resident in Con 8/8/19 at 12:21 shared with the ME "Section E.0200 A Social Worker" and modification of the submit it once it is Con 8/8/19 at 3:00 pmeeting with the Anursing the above The facility policy to Instrument revised follows in part: 1. The Assessment of the Anursing the Assessment of the Assessment of the Section E.0200 the Submit it once it is the Anursing the Anursing the Anursing the Assessment of the Section E.0200 the Section	g, grabbing). Resident #121 assistance of two staff for personal hygiene and was ing. ication Administration Record nced the resident was in (an anti-anxiety drug) 1 mg or the following identified e not coded on the 7/10/19 inhitting, kicking, scratching, imhitting, scratching, imhitting, scratching, iterly MDS Section Z. histration evidenced the Social as having completed section ction Z. reads in part: "I certify ying information accurately formation for this resident" p.m., the above findings was os Coordinator. She stated, was coded incorrectly by the d "we will be completing a MDS for Section E. and	F	641	Monitoring: The DON and RCC are responsible monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS cato monitor for compliance. All negatindings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported Quality Assurance Committee mont for review, analysis, andrecommend for change in facility policy, proced and/or practice. Completion Date: 9/20/19	dendar tive orted to the hly lations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495277	B. WING	1_1001_000	C 08/08/2019	
	PROVIDER OR SUPPLIER GE HALL NASSAWAI	oox	94	TREET ADDRESS, CITY, STATE, ZIP CODE 468 HOSPITAL ROAD IASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION	
F 657	reviews according c. At least quarter! 7. All persons who the MDS Resident such document att information. Care Plan Timing a CFR(s): 483.21(b) §483.21(b) Compr §483.21(b)(2) A compression of the comprehensive (ii) Prepared by an includes but is not (A) The attending (B) A registered nuresident. (C) A nurse aide was resident. (D) A member of forms of the resident and the resident and the resident and the resident of practicable for resident's care plant (F) Other approprises as determined or as requested by (iii) Reviewed and the am after each as real to the resident as the resident and the resident as t	ely resident assessments and to the following schedule: I have completed any portion of Assessment Form must sign esting to the accuracy of such and Revision (2)(i)-(iii) ehensive Care Plans mprehensive care plan must in 7 days after completion of assessment. Interdisciplinary team, that limited to-physician. Irrse with responsibility for the ith responsibility for the ith resident's representative(s). Its be included in a resident's ne participation of the resident representative is determined the development of the included by the resident's needs of the resident. The resident in the resident. The resident in the resident in the resident in the resident in the resident. The resident in the resident in the resident in the resident in the resident. The resident in the resident in the resident in the resident in the resident. The resident in	F 657	F657 Corrective Action(s): Resident #80's comprehensive care has been reviewed and revised to ref Resident 80's left pinky finger bliste caused by trauma, not a burn on 7/2/that it was now healed on 7/11/19. A Facility Incident & Accident Form we completed for this incident. Resident #134's comprehensive care has been reviewed and revised to ref resident #134's fall with a fracture at appropriate interventions and approat to address the fracture. A Facility Incident. Resident #121's comprehensive care has been reviewed and revised to ref resident. Resident #121's comprehensive care has been reviewed and revised to ref resident #121's current behaviors of hitting, kicking, scratching, or grabb during ADL care. As well as the nonpharmacological approaches to u	nect er was /19 or A vas plan nect nd the aches cident r this plan lect	
	comprehensive an assessments. This REQUIREME	NT is not met as evidenced		prior to psychotropic medication bei used. A Facility Incident & Accident Form was completed for this inciden	t ⁻	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495277	B. WING		C 08/08/2019		
	NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX			TREET ADDRESS, CITY, STATE, ZIP COD 468 HOSPITAL ROAD NASSAWADOX, VA 23413			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 657	review, and clinical determined that facare plan for three sample, Resident The findings included. The findings included it was determined caused from trauland failed to revisional healed on 7/2 Resident #80 was 6/22/16 with diagolimited to, Parkins Schizophrenia. Resident #80 was assessment with date) of 4/2/19. Reintact in cognitive possible 15 on the Mental Status) expressible 15 on the Mental Status of the following nursing station stored (left) pinky finger noted. Resident in party). (Name of resident (sic) give closed and not we will be a sample.)	terview, facility document al record review, it was acility staff failed to revise the e of 56 residents in the survey #80, #134, and #121. ded: led to revise the care plan when her left pinky blister was ma rather than a burn on 7/2/19; the the care plan when the blister l1/19. s admitted to the facility on noses that included but were not son's disease, convulsions, and resident #80's most recent MDS et) assessment was a quarterly an ARD (assessment reference esident #80 was coded as being function scoring 15 out of the BIMS (Brief Interview of the BIMS (Brief Interview of the BIMS) is clinical record revealed to obtained a blister on 6/30/19. Sing notes were written: Int.: "resident (sic) came up to atting that she spilled coffee on L. L. pinky finger was red, blister is her own RP (responsible Medical Doctor) made aware. The proposed in tylenol. Skin blanches. area is sent was a rea is sent was a contained a blanches. area is sent was a contained a blanches. area is accordance.		Identification of Deficient Pra & Corrective Action(s): Any/all residents may have pote been affected. A 100% review or resident comprehensive care plate conducted by the RCC and/or didentify residents at risk. Reside identified at risk as having an incomprehensive care plan will be at time of discovery and a Risk Management Incident & Accide will be completed for each incidentified. Systemic Changes: The assessment process will conbe utilized as the primary tool of developing comprehensive plan. The RCC is responsible for impute RAI Process. The nursing a process as evidenced by the 24 Report and documentation in the record/physician orders will be develop and revise comprehens of care. The Regional Nurse Conwill provide in-service training interdisciplinary care plan team mandate to develop individuality plans within 7 days of the comprehensive assessment revisions to the comprehensive as indicated with any changes it condition.	entially of all ans will be esignee to ents naccurate e corrected ent Form dent ntinue to for as of care. elementing ssessment Hours he medical used to give plans onsultant to the i on the zed care eletion of and/or care plan		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495277	B. WING	State of Actions of the Secretarion of the Secretar	C
	PROVIDER OR SUPPLIER		S 9	TREET ADDRESS, CITY, STATE, ZIP CODE 468 HOSPITAL ROAD ASSAWADOX, VA 23413	08/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
	7/1/19 1:23 p.m.: "In nurse: Resident was for blister noted to I resident concerning resident stated, "I the stated of the state	Nound assessment done by seen by wound care nurse eft pinky finger. Spoke to gorigin of non-intact blister, nink I hit it on my w/c asked again within 5 minutes to my hand between the door. When asked if she had erself resident stated "no (sic) I con door with my w/c" Area dry nage noted area 2 cm cm red in color with er absent at this time." If #80's July POS (physician wealed her wound care niged to the following order: with dermal wound cleanser, polymem (2) every three days til healed." This order was	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 pl calendar to monitor for compliance. Any/all negative findings will be report 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 facility policy, procedure, and/or practice. Completion Date: 9/20/19	an ted

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		18 81	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495277	B. WING		08/08/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX			1	STREET ADDRESS, CITY, STATE, ZIP 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(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 C X (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLÉTION IE APPROPRIATE DATE
F 657	Continued From pa	276	F6	557	
	changing story, etic superficial, with a r reddened intact sk inconsistent with a crush injury. Given wound, etiology mo	n patient's medical history and blogy unreliable. The wound is non-intact blister with mildly in underneath blister, which is burn and inconsistent with a current appearance of the lost likely an abrasion due to Plan: 1. Leave wound open to			
		nt #80's skin assessments when her abrasion/non-intact			
	documented the for Skin integrity r/t (re- pinky fingerChan Ensure resident ha	at #80's care plan dated 6/30/18 illowing: "At Risk for Impaired elated to) history of burn to age dressing as per orders. ad lid on coffee. Monitor site foins) of infections and report any ector)."	r		
	determined that he trauma rather than	not revised once it was er blister was caused from a burn. The care plan was nce her blister was healed.			
	conducted with LP the wound care nu Resident #80's blis from trauma and the an investigation ar	a.m., an interview was N (licensed practical nurse) #1 rse. When asked the cause of ster, LPN #1 stated that it was hat the facility had conducted and interviewed staff and the her blister. When asked the			
	purpose of the car purpose of the car needs of each resi important that it wa	e plan, LPN #1 stated the e plan, LPN #1 stated the e plan was to address the ident. When asked if it was as accurate, LPN #1 stated that who was responsible for	ıt .		

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 33 of 79

RECEIVED

AUG 38 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		A. BUILDI	NG		C	
	495277	B. WING _	5 COS		08/08/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWA			STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	ODE		
PRÉFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE , DEFICIENCY)	SHOULD B		
not revise the care responsible for revasked how MDS is with a resident's or floor nurses tell M Resident #80;s caplan should have blister was from the stated that it should have blister was from the stated that it should have blister was from the stated that it should have blister made I had to check for This writer made I not be found in Resident #80's would have been should have been saves area light pink in cobleeding no drainathis time. Area present on 8/8/19 at 3:18 member) #1, the assertion of the clinical recording the should have been	plan, LPN #1 stated that she dide plan that MDS was vising the care plan. When is made aware of any change ondition, LPN #1 stated that the DS. This writer showed LPN #1 are plan. When asked if her care been revised to reflect that her auma and not burns, LPN #1 lid have been. When asked if had a blister, LPN #1 stated when asked when her blister #1 stated that she wasn't sure Resident #80's clinical record. LPN #1 aware that a note could esident #80's clinical record. It she would try to find a note. P. #1. LPN #1 showed this all notepad. LPN #1 stated that bund had healed on 7/11/19, but document this assessment in when asked if Resident #80's have also been revised to reflect the healed, LPN #1 stated that the have been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised. Writer a late entry progress note documented in part, the nave been revised.		57			

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		S 0 120	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495277	B. WING		08/08/2019		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX				STREET ADDRESS, CITY, STATE, ZI 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		ON SHOULD BE COMPLÉTION HE APPROPRIATE DATE		
F 657	information was pro	age 34 concerns. No further esented prior to exit. eal antimicrobial used to rom burn wounds. This	F 6	657			
	information was ob Institutes of Health https://www.ncbi.nl 35806/. (2) Polymem-dress	tained from The National m.nih.gov/pmc/articles/PMC29 ing that is designed to elieve pain and reduce					
		ed to revise the care plan after on 6/30/18 for Resident #134.					
	2/13/13 with diagnoral limited to Alzheime blood pressure and #134's most recent assessment was a ARD (assessment Resident #134 was impaired in cognitive possible 15 on the Mental Status) example of the status of	admitted to the facility on oses that included but were not r's disease, dementia, high decrebral aneurysm. Resident MDS (Minimum Data Set) quarterly assessment with an reference date) of 6/3/18. It is coded as being severely be function scoring 00 out of BIMS (Brief Interview for m. Resident #134 was coded sive assistance with two plus					
	persons with transicoded in Section (Steady, only able tassistance" with suffransfer between Review of Residen	fers. Resident #134 was also (functional status) as "Not o stabilize with staff or surface transfers ped and chair or wheelchair."					
	The agreement provide many resident confidence of the course of the control of th	nad a fall on 6/30/18. It was dent #134 had fallen because	Į.				

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 35 of 79

RECEIVED

AUG 30 2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 08/08/2019	
		495277					
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX				STREET ADDRESS, CITY, STATE, ZIP 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	CODE	06/06/2013	
(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 CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIAT		
F 657	documented in a na (certified nursing a assist into chair. (so on fall mat. resider knee) pain. no (sich have some pain will given." Review of Resident revealed that Resident revealed that Resident preventive intervers on 6/30/18: "pressibed with fall mat' Review of Resident plan for nursing aid preventive interver 6/11/18: "Pressure	ted. The following was ursing note: "While CNA ssistant) was moving chair to ic) resident stood up and fell it (sic) has complaints of L (left) swelling noted. resident does th movement. motrin (1)(sic) It #134's care plan dated 5/2/16 dent #134 had the following fall itions in place prior to her fall ure alarm at all times, Hi/low It #134's nursing kardex (care des) revealed the following fall itions were in place as of alarm at all times, gel pommel nair, alarming seatbelt while in	F 6	57			
	revealed that Resider from the fall on 6/3 #134's physician of ordered an ACE (2 following order was left extremity loose Review of Residen notes revealed that hospital on 7/2/18 evaluation. Reside facility on 7/2/18 w "Patient's splint neand assess skin for the following from the second	Resident #134's clinical record dent #134 sustained a fracture 0/18. Review of Resident rders revealed that she was) wrap on 6/30/18. The sidocumented: "N.O. Ace wrap ly from mid thigh to ankle." It #Resident #134's nursing the she had went out to the for an Ortho (orthopedic) and #134 arrived back to the other than the following order: eds to be removed twice a day or breakdown." Patient should weight bearing on left lower					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495277	B. WING		90	C 3/08/2019
	PROVIDER OR SUPPLIER	oox	(4) (4) (4) (4)	STREET ADDRESS, CITY, STATE, ZIP (9468 HOSPITAL ROAD NASSAWADOX, VA 23413		4200
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 657	Review of Resider (treatment administ staff were implement administ staff were implement for the review of F 5/2/16, failed to refinew orders for split on 8/8/19 at 10:18 conducted with OS MDS nurse. When for updating care pupdates the care pupdates the care pupdated that the casked when the casked when the casked if a resident fracture, if she worrevised to reflect the stated that she wo expect to see care care plan, OSM #1 confirmed femur was not reflect are plan and the care plan and the ca	at #134's July 2018 TAR stration record) revealed that enting the order for her splint. Resident #134's care plan dated flect her fractured femur and int care. Sa.m., an interview was SM (other staff member)#1, the asked who was responsible blans, OSM #1 stated that MDS blans now, but was not sure are plan was updated, OSM #1 e plan was updated, OSM #1 e plan was updated for any new condition, quarterly etc. When had a fall and obtained a uld expect to see the care plan hat fall and fracture, OSM # 1 uld. When asked if she would for the new fracture on the confirmed that she would. If that Resident #134's fractured ected on her comprehensive care required for her fracture		557		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495277	B. WING _		C 08/08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	ox		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	06/06/2019
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
F 657	Institutes of Health.https://dailyrdaDrugXsl.cfm?set 00144ff8d46c. (2) ACE wrap is an stabilize joints and information was obhttps://www.acebraabout-ace-brand/oi. Complaint Deficien 3. The facility staff was revised for ide include non-pharm designed to meet the Resident #121. Resident #121 was 11/6/12 with diagnot to, unspecified den disturbance, major with severe psychia MDS (Minimum Dalassessment refere resident as having deficits and severe making skills. Und assessed as not expensional hygiene and the resident # assistance of two spersonal hygiene and Review of the Medi (MAR's) for June 2 2019 evidenced the Ativan (an anti-anx	med.nlm.nih.gov/dailymed/fda/f id=26cd56b0-edbb-74f3-e054- elastic bandage used to to reduce swelling. This tained from nd.com/3M/en_US/ace-brand/ ur-story/.	F 65		

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

AND BLAN OF CODDECTION DENTIFICATION NUMBERS		50 00 0	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495277	B. WiNG			C /08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	ox		STREET ADDRESS, CITY, STAT 9468 HOSPITAL ROAD NASSAWADOX, VA 2341:	E, ZIP CODE	30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC)	STEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 657	administration for the June 9th at 8:09 a. attempting to get up June 12th at 12:50 scratching, grabbing July 9th at 9:08 p.m grabbing July 10th at 9:43 a. grabbing July 14th at 9:48 a. (activities of daily live July 23rd at 8:29 a. out of bed, pacing the July 24th at 10:31 a scratching, grabbing July 27th at 10:14 a scratching, combative July 29th at 9:38 a. grabbing, combative July 30th at 10:13 a scratching, grabbing July 30th at 10:13 a scratching, grabbing July 31st at 9:15 a. grabbing, combative August 1st at 9:15 a. grabbing, grabbing Areview of the Concare Plan dated 11 evidenced it was not resident's behaviors or grabbing during a individualized appropriate individualized appropriate in the stratching of the concare grabbing during a individualized appropriate individualized appropriate in the stratching of the concare grabbing during a individualized appropriate in the stratching of the concare grabbing during a individualized appropriate in the stratching of the concare grabbing during a individualized appropriate in the stratching of the concare grabbing during a individualized appropriate in the stratching of the concare grabbing during a individualized appropriate in the stratching of the concare grabbing during a stratch	al approaches prior to these identified behaviors: mcombative with staff, without assistance. p.mhitting, kicking, ghitting, kicking, scratching, mhitting, scratching, mcombative during ADL care ving) mresident attempted to get the hallway a.mhitting, kicking, g. cursing a.mhitting, kicking, scratching, e during care mhitting, kicking, scratching, e during ADL care a.mhitting, kicking, scratching, e during ADL care a.mhitting, kicking, scratching, g. cursing mhitting, kicking, scratching, g. cursing mhitting, kicking, scratching,	F6	557		

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 39 of 79

RECEIVED

AUG 3 8 2019

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		495277	B. WING		na na	C /08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	ox		STREET ADDRESS, CITY, STATE, ZIP C 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		99,2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 657	(LPN #8) was internas the nurse who he PRN Ativan doses 2019. She stated to be bothered stating than get upshe gower implemented stated, "Yes, we try When asked where non-pharmacologic stated, "I didn't doo the care plan had behavioral care plan had behavioral care plan non-pharmacologic prior to the administrated, "No". When good for with PRN stated, "Fourteen corder and stated it and the care plan stated it and th	a.m., Licensed Practical Nurse viewed as she was identified ad administered each of the for June, July and August he resident does not want to a "She would rather be in bed ets agitated during ADL care." -pharmacological approaches prior to administration she to wait or offer snacks." ethe documentation of the eal interventions are she ument them." When asked if seen revised to include a n with individualized eal approaches to be attempted eat approaches and a stop date eathould have been revised. The LPN was shown the should have been revised. The LPN was shown the should have been revised. The LPN was shown the should have been revised. The LPN was shown the should have been revised. The LPN was shown the should have been revised. The LPN was shown the should have been revised. The LPN was shown the should have been revised. The LPN was shown the should have been revised.	F 6	57		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	18	495277	B. WING		C 08/08/2019
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2015
		×	946	8 HOSPITAL ROAD	
HERITAG	GE HALL NASSAWAD	OX	NA	SSAWADOX, VA 23413	
(X4) ID		TEMENT OF DEFICIENCIES	סו	PROVIDER'S PLAN OF CORRECTIO	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
				F658	
F 658		Meet Professional Standards	F 658	Corrective Action(s):	Lancaria de la companya de la compan
SS=D	CFR(s): 483.21(b)(3)(i)		Resident #80's attending physician been notified that the facility staff d	
		ar man yaganer sayaneris		administer a physician ordered treat	Mant
		prehensive Care Plans	Ü.	to a non-intact blister, failed to docu	ment
		ded or arranged by the facility,	· .	when the non-intact blister had heal	ed and
		comprehensive care plan,	E	continued to treat the non-intact blis	
	must-		1	after it had healed. Resident #80's	
		al standards of quality.		physician orders have been reviewed	
		NT is not met as evidenced		ensure all treatment orders are accur	rate. A
4	by:			Facility Incident & Accident Form	vas
		interview, staff interview,		completed for these incidents.	!
		eview and clinical record		Identification of Deficient	1
		mined that facility staff failed		Practices/Corrective Action(s):	8
		nysician's recommendations		All other residents receiving physici	an
		on-intact blister; failed to	'	ordered wound care treatments may	have
		e non-intact blister had healed	 	been potentially affected. The DON	
		d; and continued to treat the	r	ADON and/or designee will conduc	ta
		nen it was already healed for		100% review of all resident's wound	d care
1		n the survey sample, Resident		and treatment orders to identify any	Soon No.
	#80.			residents at risk. All residents identi-	fied at
		100		risk will be corrected at time of disc	overy
	The findings include	ed:		and the attending physician will be notified of each error. An Incident &	
	_ a in the Microsophia	to proper approximation to territoria		Accident form will be completed for	c each
	Resident #80 was a	admitted to the facility on		negative finding.	Cacii
		ses that included but were not		<i>g</i> g .	
	limited to Parkinsor	's disease, convulsions, and		Systemic Change(s):	
	Schizophrenia. Res	ident #80's most recent MDS		The facility policy and procedure ha	s
	(minimum data set)	assessment was a quarterly		been reviewed and no revisions are	
	assessment with ar	ARD (assessment reference		warranted at this time. The nursing	25
		sident #80 was coded as being		assessment process as evidenced by	the
Ì		inction scoring 15 out of		24 Hours Report, documentation in t	he
		BIMS (Brief Interview of		medical record and physician orders remains the source document for the	
	Mental Status) exar	m.		development and monitoring of care	
				which includes, obtaining, transcribi	no I
		#80's clinical record revealed		and administering physician ordered	
		btained a blister on 6/30/19.		wound care and treatments per physi	cian
	The following nursing	ng notes were written:		order. Licensed staff will be inservice	ed by
			<u> </u>	the DON and/or regional nurse const	ultant
	6/30/19 at 7:20 a.m	.: "resident (sic) came up to	27	on the policy & procedure for wound	
	nursing station stati	ng that she spilled coffee on L		treatment administration per physicia	an

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	ох		STREET ADDRESS, CITY, STATE, ZI 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 658	(left) pinky finger. L noted. Resident is party). (Name of M aware. resident (side blanches. area is considered blanches. Besident was for blister noted to resident concerning resident stated, "I that (wheelchair)" When the wheelchair spilled coffee on he think I hit my hand no bleeding no drance (centimeters) x 0.5 pigmented skin lay Review of Resident was chanced blanches blanc	pinky finger was red, blister her own RP (responsible D (Medical Doctor) made by given tylenol (1). skin losed and not weeping." "Intact blister to left hand oinky ne (2) applied per order." Wound assessment done by as seen by wound care nurse left pinky finger. Spoke to gorigin of non-intact blister, hink I hit it on my w/c n asked again within 5 minutes it my hand between the door "When asked if she had erself resident stated "no (sic) I on door with my w/c" Area dry inage noted area 2 cm cm red in color with er absent at this time." It #80's July POS (physician vealed her wound care nged to the following order: y with dermal wound cleanser, polymem (3) every three days ntil healed." This order was	F 6	Monitoring: The DON is responsible for compliance. The DON and observe 3 treatment pass of weekly to monitor for come Any/all negative findings corrected at time of discoved disciplinary action will be needed. Aggregate finding audits will be reported to the Assurance Committee quareview, analysis, and recompletion Date: 9/20/1	d/or ADON will observations upliance. will be very and taken as gs of these the Quality urterly for mmendations ty, procedure,

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 22	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495277	B. WING _		0.8	C 3/08/2019
	PROVIDER OR SUPPLIER	ox		STREET ADDRESS, CITY, STATE, ZIP O 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		700723.10
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 658	finger. Patient unce described to nurse questioned my (sic reported catching h She then said it ma questioned her as twas unclear. Given changing story, etic superficial, with a nreddened intact ski inconsistent with a crush injury. Given wound, etiology mounknown causeP air" Review of Resident revealed that facility wound care physicileave her abrasion/ Review of Resident (treatment administ facility staff continuabrasion/non-intact dressing until 7/19/discontinued. Review of Resident facilet to document blister had healed. On 8/8/19 at 10:39 conducted with LPN #1, the wound care process (how an or physician's recommend to the superficial of	act blister on her left 5th ertain as to cause. She a wheelchair injury. When MD (medical doctor), she ler finger against door jam. By have been a burn. When I to the source of the burn, she patient's medical history and blogy unreliable. The wound is on-intact blister with mildly in underneath blister, which is burn and inconsistent with a current appearance of the likely an abrasion due to lan: 1. Leave wound open to the work of the likely and a staff failed to implement the anis recommendations to inon-intact blister open to air.	F 65	58		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. 37 10	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495277	B, WING		C 08/08/2019
NAME OF	PROVIDER OR SUPPLIER	 -		STREET ADDRESS, CITY, STATE, ZIP 9468 HOSPITAL ROAD	
HERITAC	GE HALL NASSAWAD	OOX		NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE COMPLÉTION E APPROPRIATE DATE
F 658	recommendations. care physician's reconsidered an order made the nurses at but that she forgot stated that she forgot stated that she diding Resident #80's fing physician's evaluat marks meant on the check marks meant administered. LPN #80's July 2019 TA dressing her wound that the nurses cout they completed the the dressing. When document that a tragiven when it was anot okay to docum When asked when healed, LPN #1 state check her clinical record with the marked with the marked with RN nurse. When asked the MAR (medication administered. When document that a tragical record)/TARs, RN meant a medication administered. When document that a tragical record with the document that a tragical record with that a tragical record with the document that a tragical record with	und care physician's LPN #1 stated that the wound commendations should be er. LPN #1 stated that she had ware of the new order verbally to write the order. LPN #1 n't recall seeing a dressing on per after the wound care ion. When asked what check to TAR, LPN #1 stated that that a treatment was #1 confirmed that Resident R revealed that staff were d until 7/19/19. LPN #1 stated all have just documented that to dressing but didn't really do to asked if it was okay to the eatment or medication was ent care that was not provided. Resident #80's wound had that she would have to the could not be found in tical record. LPN #1 stated that d a note. a.m., interview was I (Registered Nurse) #2, a floor d what check marks meant on on administration #2 stated that check marks on and/or treatment was en asked if it was okay to the eatment was administered ministered, RN #2 stated that it	F6	58	
	-	a.m., an attempt was made to			

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED	
		495277	B. WING	Accepted 5 or of	01	C 3/08/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		3/00/2013
(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 CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 658	Continued From pa		F6	558		
	administered the pe	o documented that she olymen treatments on 7/16/19 ould not be reached for an				
	interview was cond Resident #80 state	ximately 1:30 p.m., an ucted with Resident #80. d that she remembered having not sure how long she had the per.				
	conducted with LPI writer her personal Resident #80's work that she forgot to do the clinical record. Resident #80's July were still treating h 7/19/19 even thoug 7/11/19. LPN #1 gaprogress note date part, the following: Resident pinky fing nurse. At this time area noted no blee blanchable at this tat this time."	o.m., further interview was N #1. LPN #1 showed this notepad. LPN #1 stated that and had healed on 7/11/19 but ocument this assessment in LPN #1 confirmed that y 2019 TAR reflected that staffer wound on 7/16/19 and the wound had healed on the this writer a late entry d 8/8/19 that documented in "Late Entry for 7/11/19: er was assessed by wound area light pink in color no open ding no drainage noted. Area ime. Area presents as healed				
	member) #1, the A ADON (Assistant D aware of the above staff member) #1 s	e.m., ASM (administrative staff dministrator, and ASM #2, the director of Nursing) were made a concerns. CSM (Corporate tated that the facility used leir policies as a professional				
		, "Medication and Treatment sin part, the following:				

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 45 of 79

RECEIVED

AUG 3 n 2019

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 10 10	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER	ox		STREET ADDRESS, CITY, STATE, ZIP COE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	2 PG	HOULD BE COMPLETION
F 658	written orderDrug recorded on the Ph resident's chart."	ge 45 De administered only upon the and biological orders must be ysician's Order Sheet in the con was presented prior to exit.	F€	658	
F 686	(1) Tylenol Tablet 3 Treats minor aches fever. This informal National Institutes of https://www.ncbi.nl T0008785/?report= (2) Silvadene- topic prevent infections f information was ob Institutes of Health https://www.ncbi.nl 35806/. (3) Polymem-dress facilitate healing, re inflammation, https://	25 mg (Acetaminophen)- and pains and also reduces ation was obtained from The of Health. m.nih.gov/pubmedhealth/PMH details. al antimicrobial used to rom burn wounds. This tained from The National m.nih.gov/pmc/articles/PMC29 ing that is designed to elieve pain and reduce ://polymem.com. Prevent/Heal Pressure Ulcer	F	686	
	resident, the facility (i) A resident receive professional stands pressure ulcers an ulcers unless the irredemonstrates that (ii) A resident with professional s	sure ulcers. prehensive assessment of a		F686 Corrective Action(s): Resident #124's attending physinotified that the facility staff fail assess, measure, implement previous to promote the healing of 1 pressure injury. A facility Inci Accident form was completed for incident.	led to ventative of a Stage dent &

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
		A. BUILDING	l c
	495277	B. WING	08/08/2019
NAME OF PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE HALL NASSAWADO	n x	9468 HOSPITAL ROAD	
HERITAGE HALE WASSAWADO		NASSAWADOX, VA 23413	
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTTING TAG CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES O	ULD BE COMPLETION
by: Based on observation record review and far facility staff failed to and treatment to prea a pressure injury for survey sample, Resident #124 was a 9/20/18 with diagnost to, stroke and diabed (Minimum Data Set) assessment referenthe resident as having memory deficits. The assistance of two stadependent for transf Conditions the resided developing pressure stage IV pressure in full thickness tissue tendon, or muscle. So present on some paresident was on a lofacility wound nurse Nurse-LPN #9) performith Certified Nursing was providing assist resident on her side this surveyor observing was red. After compare to the providing assist resident on her side this surveyor observing was red. After compare to the providing assist resident on her side this surveyor observing as a providing assist resident on her side this surveyor observing a providing assist resident on her side this surveyor observing a providing a said the surveyor observing a p	veloping. IT is not met as evidenced on, staff interview, clinical acility document review the provide the necessary care event and promote healing of of 1 of 56 residents in the ident #124. c. admitted to the facility on ses to include but not limited tes. The current MDS of an annual with an oce date of 7/1/19 assessed ong long and short term one resident required extensive aff for bed mobility and fers. Under section M. Skin ent was coded as at risk for e ulcers/injuries and having a higury (defined in the MDS as a loss with exposed bone, slough, eschar may be orts of the wound bed). orm., an observation of the onge was conducted. The ow air loss mattress. The	Identification of Deficient Pract and Corrective Action(s): All other residents with wound ca prevention and treatment orders motentially been affected. The DO ADON, Wound nurse and/or Unit Manager will conduct 100% skin and a 100% audit of all Pressure is prevention orders to identify any materisk for alterations in skin integ without proper monitoring, assess and tracking and missing prevention items. Any negative findings will corrected at the time of discovery disciplinary action taken as indicated facility Incident and Accident for the completed cach negative finding. Systemic Change(s): The facility Policy and Procedure Wound Care has been reviewed a changes are warranted at this time nursing staff will be inserviced by Wound Care Nurse and/or the DO the facility's Pressure Ulcer Treat and Prevention Policy and Proced training will include the weekly shassessment process and the applic physician ordered pressure relievidevices.	re lay have N, audit njury residents rity ment on be and ted. A n will ig. for nd no All the DN on ment ure. The kin ation of

	10 1 011 III E 101 II IE	Q MEDICAID SETTICES			ONI DINC	<u>7. 0936-039 j</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N. 10	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495277	B. WING		08	C 3/08/2019
NAME OF 1	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
HERITAC	SE HALL NASSAWAD	ox		9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	PREFIX TAG		OTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
F 686	to have redness, the not blanchable in the stated she was not and that the resider "heel float" boots, a order for skin prep. The wound nurse a documented that diresident was noted the left heel. The acm (centimeters) in depth. The area wouter edges and " with difficulty." The prep to be applied healed as there had initiated. Further clinical receducumented skin in staff was 10/11/18. There was no documented skin in staff was 10/11/18. There was no documented skin in staff was 10/11/18. There was no documented skin in staff was 10/11/18. On 8/8/19 at 9:47 awound nurse was occlarify what she methe area "blanches a stage I non-blances a stage I non-blances as tage I non-blances as the property of the left property of the left property was normal.	ssed the heel and it was found e tissue was boggy and was he middle. The wound nurse aware of this pressure injury ht was utilizing the specialty and there had been a previous assessed the left heel and turing the dressing change the to have a reddened area to area was boggy, measuring 3.1 a length x 2.8 cm wide with no as blanchable closer to the atthe center of area blanches a wound nurse ordered skin to the left heel every shift until do not been a treatment.		Monitoring: The DON is responsible The DON, ADON and/o will review all residents inspection sheets to iden with a potential skin alte requires assessment, mea and monitoring. The DO Unit Managers will com rounds weekly to monito ordered preventive press are in place. Any/all neg will be addressed at time additional inservice train disciplinary with will be that time. The results of sent to the Quality Assun monthly for review, anal recommendations for ch policy, procedure, and/o Completion Date: 9/20	r Wound nurse weekly skin tify any residents ration that asuring, tracking N, ADON and/or plete 3 random or for physician ure injury devices ative findings of discovery and ting and/or administered at the audits will be rance Committee lysis, and ange in facility r practice.	

DENTISION NI BARED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495277	B. WING		3	/08/2019
	PROVIDER OR SUPPLIER	ох		STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 686	further stated, "si may not have been had oversight of the schedule to ensure stated, "The unit me stated during the recertified nurse aides she is to document Form and then reported charge nurse. The do an assessment should include a declinical record, if it relayed to the wound assess the wound. Gloor nurses do not does. A stage I pressure MDS as: Intact skin of a localized area prominence. On 8/8/19 at 10:20 Skin Check Form of CNA #7 had identified Resident #124 hee Practical Nurse #8 the resident that shoulified or had revified or had revied she did not know, was asked where the schedule was post "I am in the process" I am in the process	age 48 It the nurses station, she ince we have had turn over it is conveyed." When asked who is weekly wound assessment is they are being conducted she anagers." The wound nurse esident shower days if the is (CNA) finds a skin concern it on the CNA Skin Check out the area found to the is charge nurse will then go and of the area. The assessment escription of the area in the is a pressure injury this is and nurse so that she can The wound nurse stated the stage pressure injuries she ulcer/injury is defined in the in with non-blanchable redness usually over a bony a.m., a review of the CNA completed on 8/5/19 evidenced field reddened areas to els. The nurse (Licensed by who was assigned to care for infit was asked if she was ewed the CNA Skin Check is, she stated, "No, I didn't see asked where the weekly skin fulle was located, she stated The right side unit manager the weekly skin assessment ed for the nurses. She stated, is of making one now, I have to When asked where would I	F 6	86		

PRINTED: 08/19/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495277 B. WING 08/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD HERITAGE HALL NASSAWADOX NASSAWADOX, VA 23413 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID !D PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 686 | Continued From page 49 F 686 find in the clinical record the weekly skin assessments conducted by a licensed nurse, she stated, "Honestly, I'm going to tell you that it has probably not been done." On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing. The facility policy titled Prevention of Pressure Ulcers/Injuries revised July 2017 reads in part: Purpose-The purpose of this procedure is to provide information regarding identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Risk Assessment: 1. Assess the resident on admission for existing pressure ulcer/injury risk factor. Repeat the risk assessment weekly and upon any changes in condition. The National Pressure Ulcer Advisory Panel, European Pressure Ulcer Advisory Panel and Pan Pacific Pressure Injury Alliance. Prevention and Treatment of Pressure Ulcers: Quick Reference

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

§483.25(d) Accidents.

SS=D + CFR(s): 483.25(d)(1)(2)

Guide, Emily

alterations to intact skin.

Haesler (Ed.). Cambridge Media: Osborne Park,

4. Include a comprehensive skin assessment as part of every risk assessment to evaluate any

Australia; 2014. Page 17 reads, in part:

5. Document all risk assessments.

F 689 Free of Accident Hazards/Supervision/Devices

Event ID: W1Y811

Facility ID: VA0116

F 689

Corrective Action(s):

Resident #8's attending physician has been notified that facility staff failed to

serve her coffee with a protective lid on 8/6/19. A facility incident and accident

form has been completed for this incident.

If continuation sheet Page 50 of 79

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

495277 B. WING	O8/08/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX STREET ADDRESS, CITY 9468 HOSPITAL ROAD NASSAWADOX, VA	Y, STATE, ZIP CODE D
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERE	S PLAN OF CORRECTION (XS) ECTIVE ACTION SHOULD BE COMPLETION ENCED TO THE APPROPRIATE DATE DEFICIENCY)
The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, clinical record review and facility document review the facility staff failed to provide a physician ordered safety device (a lidded cup) to promote safety for 1 of 56 residents in the survey sample, Resident #8. The findings include: Resident #8 was admitted to the facility on 5/6/11 with diagnoses to include but not limited to, legal blindness and history of major depressive disorder, recurrent, severe with psychotic symptoms. The current MDS (Minimum Data Set) a quarterly with an assessment reference date of 7/8/19 coded the resident as scoring a 6 out of a possible 15 on the Brief Interview for Mental Status (BIMS), indicating the resident was coded as requiring limited assistance with one person physical assist with eating, and transfers, All other reside protective ids been affected. Unit Manager review of all re ordered protective ids been affected. Unit Manager review of all re ordered protective ids been affected. Unit Manager review of all re ordered protective ids been affected. Unit Manager review of all re ordered protective ids been affected. Unit Manager review of all re ordered protective ids been affected. Unit Manager review of all re ordered protective ids been affected. Unit Manager review of all re ordered protective ids been affected. Unit Manager review of all re ordered protective ids been aftered to review of finding. The at notified at ris of discovery aftered identified at ris of discovery aftered identi	dents with physician ordered for hot liquids may have The DON, ADON and/or will conduct a 100% esidents with physician etive lids to hot liquids to ents at risk. All residents sk will be corrected at time and an Incident & Accident completed for each negative ttending physician will be the incident. Inge(s): Dicy and procedure has and no revisions are his time. The DON and/or consultant will inservice all sing staff regarding residents of hot liquids. Esponsible for maintaining he DON/designee will weekly inspections of all physician ordered lids for monitor for compliance. We findings will be the ne of discovery and the of disco

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 51 of 79

RECEIVED

AUG 30 2019

PRINTED: 08/19/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495277 08/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD HERITAGE HALL NASSAWADOX NASSAWADOX, VA 23413 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLÉTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 689 Continued From page 51 F 689 of legal blindness. One of two goals was to ensure the resident would not have injuries thru the next review. One of the interventions was listed as: Keep the resident's environment free of small objects on the floor, very hot liquids and toxic liquids. The care plan did not include a hot safety beverage device such as a lidded cup. On 8/5/19 at 1:19 p.m., the resident was observed asleep in bed, the head of the bed was elevated. The bedside table was positioned over the resident's torso. The resident's gown was visibly wet from spilled coffee on the chest area. A regular mug of coffee without a lid was observed on the lunch tray almost empty. A nurses noted dated 8/5/19 entered at 6:11 p.m., read: "Late entry for 1330 (1:30 p.m.); CNA (certified nursing assistant) reported that today at lunch resident spilled her coffee on her front of her gown. Nurse went in and immediately assessed resident's skin to her chest and abdomen, no redness or discoloration was noted. Resident asked about this and she stated, "oh my coffee wasn't hot, it was cool, I am fine." MD (Medical Doctor) and RP (Representative Party) notified. Hot liquids safety evaluation done and resident is at risk for injury from spills of hot liquids. New order obtained for lidded cup for all hot liquids." This nurses note was entered by the Director of Nurses (DON).

On 8/6/19 at 9:30 a.m., this surveyor and surveyor #1 observed the resident was in bed, awake. The resident was asked if she had eaten breakfast or drank her coffee already. She stated, "No, I couldn't get the lid off (coffee cup)." The resident stated she would like another cup of coffee. The two surveyors went to the nurses

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\$10 DESCRIPTION	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. DOILD		С
		495277	B. WING		08/08/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX			STREET ADDRESS, CITY, STATE. ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFI TAG		OULD BE COMPLETION
F 689	resident's request. she would get the r CNA came back from coffee, she stopped asked if the resident coffee, she stated if CNA #5 continued inside the room the if the resident was mug, she questioned that the resident was lidded cup. When a "Because she is blinderself and burn he don't normally work Closet Care Plan was resident's closet." opened and the CN surveyor and CNA. lidded cup for all he proceeded to place handed the coffee cup reached resident stated, "It's the cup and was got this time, this surveyuntil the coffee tem Surveyor #1 then e by the Dietary Manwas obtained, the the between the 152 dedegree mark, indicated grees Fahrenhei kitchen staff had obtained to the degrees Fahrenhei kitchen staff had obtained to handing it come to handing it come in the degree mark indicated the pietary Management of the degree mark indicated the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee tem Surveyor #1 then endegrees Fahrenhei kitchen staff had obtained the coffee t	and informed the staff of the At this time CNA #5 stated resident a cup of coffee. The om the kitchen with a cup of at the nurses station and at needed a special cup for the the staff did not respond to her. To the resident's room. Once to the resident's room. Once to have the coffee in a regular red it and stated to the surveyor as blind and probably needed a asked why, she stated, ndso she doesn't spill it on reself." The CNA stated, "I with her, it should be on the which is taped inside the The Resident's closet was NA Care Plan was reviewed by There was no reference for a post liquids. The CNA then to the resident. Once the I the resident. Once the I the resident's lips, the stoo hot!" The CNA then took ong to add cold water to it. At eyor asked the CNA to hold off perature was obtained. Intered the room accompanied ager, the coffee temperature hermometer reading stopped agere mark and the 154 atting the coffee temperature hermometer reading stopped agere mark and the 154 atting the coffee temperature hermometer reading stopped agere mark and the 154 atting the coffee temperature hermometer reading stopped agere mark and the 154 atting the coffee temperature hermometer reading stopped agere mark and the 154 atting the coffee temperature off to her, she stated, "No". Her stated the kitchen staff ed the resident's coffee	F	589	
		o it leaving the kitchen, he	e V		

PRINTED: 08/19/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING _ COMPLETED 495277 B. WING 08/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD HERITAGE HALL NASSAWADOX NASSAWADOX, VA 23413 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **HEGULATORY OR LSC IDENTIFYING INFORMATION)** DATE TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 | Continued From page 53 F 689 further stated coffee should not be higher than 150 degrees Fahrenheit when released to the floors. The Dietary Manager stated the kitchen had received a new order yesterday evening for the resident to be served all hot beverages in a lidded cup. CNA #5 stated she was not aware of this new order. At this time both surveyors went to the kitchen. Two kitchen staff were interviewed. Food Service Worker #10, who was in the process of washing dishes stated she had placed on the tray a lidded cup with coffee to be served to the resident this morning for breakfast. Food Service Worker #11, who handed the coffee in a regular mug to CNA #5 stated she was not told nor did she ask who the coffee was for. She also stated she did not temp the coffee before it left the kitchen. The Dietary Manager was asked how many lidded cups were in the facility and stated, "We have 7 lidded cups and 3 residents that use them currently, including Resident #8." The facility policy titled Safety of Hot Liquids revised 10/2014 was reviewed. The policy indicated a Hot Liquid Safety Evaluation was be to completed on all residents upon admission, readmission and on change in condition. A Hot Liquid Safety Evaluation had never been done for Resident #8. The policy further reads, in part: 1. The potential for burns from hot liquids is considered an ongoing concern among residents

conditions.

with weakened motor skills, balance issues, impaired cognition, and nerve or musculoskeletal

Such interventions may include:

4. Once risk factors for injury from hot liquids are identified, appropriate interventions will be implemented to minimize the risk from burns.

a. Maintaining a hot liquids serving temperature of not more than 150 degrees Fahrenheit;

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

		78' 89		(X3) DATE SURVEY COMPLETED	
	495277	B. WING		C 08/08/2019	
	ox		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	1 00/00/2010	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE COMPLETION	
b. Serving hot beve 5. Food service sta foods temperatures requirements but detemperatures to pre Table 1. Time and Terious Burns-Time Burn to Occur for to 155 degrees Fahre Referenced from http://www.bt.cdc.gr. The facility Incident Resident #8 read in right side unit mana Narrative of descrippages, if needed): (with) her coffee on received another curon of the find Drug Regimen is Frough Regimen is From CFR(s): 483.45(d) Unnece Each resident's druunnecessary drugs drug when used- §483.45(d)(1) In exchaption of the find Service of the find Drug Regimen is From CFR(s): 483.45(d) Unnece Each resident's druunnecessary drugs drug when used- §483.45(d)(1) In exchaption of the find Service of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Service of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s): 483.45(d)(1) In exchaption of the find Drug Regimen is From CFR(s):	grages in a cup with a lid; If will monitor and maintain If that comply with food safety If not exceed recommended In a sevent scalding. If the memberatures Relationship to If the Required for a 3rd Degree Imperatures between 148 and Inheit is 1-2 seconds. If the memberatures between 148 and Inheit is		F757 Corrective Action(s): Resident #128's attending physicia been notified that the facility admir the incorrect dose of Humalog insu 8/6/19. A facility medication error has been completed for this inciden RN # 2 has received one on one edregarding medication administratio which included a focus on the accur	tistered lin on form t. ucation	
2-00.40(a)(a) MILLIO	out adequate monitoring, of	×			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR L Continued From pa b. Serving hot beve 5. Food service sta foods temperatures requirements but do temperatures to pre Table 1. Time and 1 Serious Burns-Time Burn to Occur for te 155 degrees Fahre Referenced from http://www.bt.cdc.gr The facility Incident Resident #8 read in right side unit mana Narrative of descrip pages, if needed): (with) her coffee on received another cu On 8/6/19 at approx Administrator and E informed of the find Drug Regimen is Fr CFR(s): 483.45(d)(§483.45(d) Unnece Each resident's dru unnecessary drugs drug when used- §483.45(d)(1) In ex duplicate drug thera §483.45(d)(2) For ex §483.45(d)(2) For ex	PROVIDER OR SUPPLIER SE HALL NASSAWADOX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 b. Serving hot beverages in a cup with a lid; 5. Food service staff will monitor and maintain foods temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. Table 1. Time and Temperatures Relationship to Serious Burns-Time Required for a 3rd Degree Burn to Occur for temperatures between 148 and 155 degrees Fahrenheit is 1-2 seconds. Referenced from http://www.bt.cdc.gov/masscasualties/burns.asp The facility Incident Report dated 8/6/19 for Resident #8 read in part and was signed by the right side unit manager: Narrative of description of injuries (use additional pages, if needed): Resident received lidded cup (with) her coffee on breakfast tray-resident received another cup of coffee in a regular cup. On 8/6/19 at approximately 10:50 a.m. the Administrator and Director of Nursing were informed of the findings. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	FORRECTION A BUILDIN 495277 B. WING PROVIDER OR SUPPLIER SE HALL NASSAWADOX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 b. Serving hot beverages in a cup with a lid; 5. Food service staff will monitor and maintain foods temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. Table 1. Time and Temperatures Relationship to Serious Burns-Time Required for a 3rd Degree Burn to Occur for temperatures between 148 and 155 degrees Fahrenheit is 1-2 seconds. Referenced from http://www.bt.cdc.gov/masscasualties/burns.asp The facility Incident Report dated 8/6/19 for Resident #8 read in part and was signed by the right side unit manager: Narrative of description of injuries (use additional pages, if needed): Resident received lidded cup (with) her coffee on breakfast tray-resident received another cup of coffee in a regular cup. On 8/6/19 at approximately 10:50 a.m. the Administrator and Director of Nursing were informed of the findings. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or	### A SUMMARY STATEMENT OF DEFICIENCIES ### HALL NASSAWADOX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FUIL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 54 b. Serving hot beverages in a cup with a lid; 5. Food service staff will monitor and maintain foods temperatures that comply with food safety requirements but do not exceed recommended temperatures to prevent scalding. Table 1. Time and Temperatures Relationship to Serious Burns-Time Required for a 3rd Degree Burn to Occur for temperatures staff will burn to serious Burns-Time Required for a 3rd Degree Burn to Occur for temperatures staff will burn to serious Burns-Time Required for a 3rd Degree Burn to Occur for temperatures between 148 and 155 degrees Fahrenheit is 1-2 seconds. Referenced from hitp://www.bt.cdc.gov/masscasualities/burns.asp The facility Incident Report dated 8/6/19 for Resident #8 read in part and was signed by the right side unit manager. Narrative of description of injuries (use additional pages, if needed): Resident received lidded cup (with) her coffee on breakfast tray-resident received another cup of coffee in a regular cup. On 8/6/19 at approximately 10:50 a.m. the Administrator and Director of Nursing were informed of the findings. Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) \$483.45(d) (Innecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- \$483.45(d)(1) In excessive dose (including duplicate drug therapy); or has been completed for this inciden RN # 2 has received one on one edure regarding medication error has been completed for this inciden RN # 2 has received one on one edure regarding medication error has been completed for this inciden RN # 2 has received one on one edure regarding medication error has been completed for this inciden RN # 2 has received one on one edure regarding medication error has been completed for this inciden RN # 2 has received one on one edure	

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 55 of 79

RECEIVED

AUG 38 2019

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 II 2000	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277			C 08/08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD		ST 94	REET ADDRESS, CITY, STATE, ZIP CODE 68 HOSPITAL ROAD ASSAWADOX, VA 23413	1 00/08/2019
(X4) ID PREFIX TAG	(EACH DEFIC!ENC	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 APPROPOLICIENCY)	D BE COMPLETION
F 757	y483.45(d)(5) In the consequences whis reduced or disconted with stated in paragraph section. This REQUIREME by: Based on staff into and clinical record facility staff failed to (Resident #128) in from unnecessary units of insulin. The findings included Resident #128 was 6/4/2018, with the 7/30/2019. The resoft 8/4/2019. The resoft 8/4/2019. The lanot limited to, type diabetic neuropath pancreas, and more reas, and more reas, and more reas, and more reas and more reasonable reas	e presence of adverse ch indicate the dose should be inued; or combinations of the reasons as (d)(1) through (5) of this NT is not met as evidenced erview, facility document review review, it was determined that to ensure one of 56 residents the survey sample was free medication; specifically excess led: Is admitted to the facility on most recent readmission on sident was on hospice care as stest diagnoses included, but 2 diabetes mellitus with y, and pseudocyst of rbid obesity. Ost recent MDS (minimum ent was a 14 day scheduled in ARD (assessment reference isident #128 was coded as nitive function scoring 15 out of BIMS (brief interview for	F 757	Identification of Deficient Practices and Corrective Action(s): All other residents receiving sliding sinsulin may have potentially been affected. A 100% audit of all resident with sliding scale insulin orders will conducted to identify residents at risk residents identified at risk will be corrected at time of discovery and appropriate disciplinary action and inservice training will be administered warranted. An Incident and Accident will be completed for each negative finding. 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 on the facility policy and procedure by the fregarding the administration of medications per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of medications per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of sliding scale insulin per physician orders to include the proper administration of the scale prope	e DON der. defor ider. def

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2000 5 C 5 C 2 C 5 C 5 C 5 C 5 C 5 C 5 C 5 C	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	ox		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
F 757	plan dated 8/1/2011 following document for hyper/hypoglyce (related to) diabete free from complicat through next review Continue diet as or encourage dietary excessive appetite. Monitor blood sugar (medical doctor) permedications as ord. A review of Reside dated 7/30/2019, reorder related to the "Humalog (1) 10 ur Kwikpen inject sub meals) & hs (at bed 100-125=2u (units) 126-200=4u 201-249=6u 250-299=8u 300-349=10u 350-400=12u >401=14u" Review of Residen medication administ that on 8/6/19, Resilevel measured 16/10 units of sliding sunits of insulin. Further review of Frevealed no negative.	9 revealed, in part, the tation: "Problem / Need. Risk emia (high/low blood sugar) r/t s. Resident #128 will remain tions associated with Diabetes v. Approaches include: dered; Monitor intake and compliance; Monitor for thirst, and excessive voiding; ars as ordered and notify MD er order; Administer lered. Int #128's physician orders, evealed in part, the following treatment of diabetes: Inits/ml. Generic: Insulin Lispro q (subcutaneous) ac (with dtime) per sliding scale:	F 75	57	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER		32	STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) 1D PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLETION
F 757	conducted with RN nurse who administrate insulin. RN #2 was indicate on the MA marks mean that it what it means to a sliding scale, RN # given per order." units of Humalog blood glucose lever recall that." When outcomes of adminits of Humalog, would drop, go into On 8/8/19 at apprenentative was con (OSM) #5, the pha would be any neground administering 10 to Humalog for a blo stated, "10 units is	S a.m., a phone interview was N (Registered Nurse) #2, the stered the 6 extra units of a asked what the check marks AR. RN #2 stated, "Check t was given". When asked, administer medications on a #2 stated, "Those are units When asked regarding the 10 administered on 8/6/2019 for a el of 163, RN #2 stated, "I don't asked what are the negative nistering the wrong number of staff #2 responded, "sugar		757	
	There was no rec	emic; a significant med error." ord of a blood sugar check 30 administration of 10 units of 2019.			
	conducted with ac (ASM) #2, the AD nursing). When a administering 10 ordered 4 units fo ASM #2 stated th	p.m., an interview was dministrative staff member ON (assistant director of sked the side effects of units of Humalog vs. the or a blood sugar reading of 163, at six extra doses was not t resident could possibly			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	14 4		STRUCTION	1 miles - 1 mile	E SURVEY PLETED	
		405277	B. WING			C 08/08/2019		
	The second secon	495277	B. WING			1 08/	08/2019	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E HALL NASSAWAD	ox	3		OSPITAL ROAD			
				NASSA	WADOX, VA 23413			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 757	and ASM #2, the Al	-	F 7	57			1	
	(revised December (3). Medications m	ust be administered in e orders, including any						
	the individual admi record in the reside a. The date and tir administered; b. The dosage; c. The route of add d. The injection sit e. Any complaints drug was administe f. Any results ach were observed; and	e (if applicable); or symptoms for which the ered; eved and when those results d nd title of the person						
	analog indicated to adults and children information was ob Institutes of Health	Psychotropic Meds/PRN Use 3)(e)(1)-(5)	 F7	58	F758 Corrective Action(s): Resident #121's attending physician been notified that the facility staff for to implement non-pharmacological approaches prior to administration of PRN Ativan and failed to obtain a state for PRN Ativan. A Facility Inc. & Accident Form has been complete this incident.	ailed of top cident		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	
				9468 HOSPITAL ROAD	
HERITAG	E HALL NASSAWAD	OX		NASSAWADOX, VA 23413	
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	
E 750				Identification of Deficient Pr	actice(s)
F 758	Continued From pa	±∞		All other residents receiving P	RN
		ychotropic drug is any drug that		psychotropic medications may	
		es associated with mental	ke	potentially affected. The DON	
		avior. These drugs include,		and/or Pharmacy consultant wi	
	but are not limited t	o, drugs in the following		the medication orders of all res	
	categories:			receiving PRN psychotropic m	edication
	(i) Anti-psychotic;			to identify all others that do no	
	(ii) Anti-depressant			non-pharmacological approach attempted prior to administrati	
	(iii) Anti-anxiety; an	d		do not have stop dates. Any/al	I negative
	(iv) Hypnotic			findings will be communicated	to the
				attending physicians for correc	
		ehensive assessment of a	A Facility Incident & Accider		
	resident, the facility	must ensure that		be completed for each negative	: finding.
	§483.45(e)(1) Resi	dents who have not used		Systemic Change(s):	
		are not given these drugs		The facility Policy and Proced	
		ion is necessary to treat a	ř	been reviewed. No revisions a	
	specific condition a	is diagnosed and documented	l	warranted at this time. All nur will be inserviced by the DON	
	in the clinical recor	d;	Ť	regional nurse consultant for p	
				administration and monitoring	
		dents who use psychotropic		psychotropic medication to inc	
		ual dose reductions, and	1	ensuring gradual dosage reduc	tion
		an effort to discontinue these		recommendations are being ad the attending physician.	dressed by
	drugs;			Manitaring	
			ı	Monitoring: The DON is responsible for ma	aintaining
		idents do not receive	:	compliance. The DON/designe	
		pursuant to a PRN order		complete weekly physician ord	
		ition is necessary to treat a		MAR audits coinciding with th	
		condition that is documented		calendar to monitor complianc	
	in the clinical recor	d; and		negative findings will be corre	
	0400 45/ 2/0 551	F 1 of		immediately and appropriate d	591 C C C C C C C C C C C C C C C C C C C
		l orders for psychotropic drugs	į	action will be taken as necessa	
		ays. Except as provided in	1	Aggregate findings of these au provided to the Quality Assura	
		e attending physician or		Committee for review, analysis	
		oner believes that it is	15	recommendations for change in	
		PRN order to be extended		policy, procedure, and/or pract	
		e or she should document their		Completion Date: 9/20/19	
	rationale in the res	ident's medical record and	ř	TO STATE OF THE ST	į ⁸

W	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING		COMP	COMPLETED		
		495277	B. WING	(45)	08/0) 08/2019
	PROVIDER OR SUPPLIER	ox		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 758	indicate the duration §483.45(e)(5) PRN drugs are limited to renewed unless the prescribing practition the appropriateness. This REQUIREMED by: Based on staff interest and facility document to ensure 1 of 56 rewas free from unner Resident #121. The implement non-phase to administration of and failed to obtain (PRN) Ativan. The findings including Resident #121 was	orders for anti-psychotic 14 days and cannot be attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced exview, clinical record review ent review the facility staff failed esidents in the survey sample esessary psychotropic drugs, e facility staff failed to ermacological approaches prior the anti-anxiety drug Ativan a stop date for as needed es: admitted to the facility on	F 7	58		
	to, unspecified dendisturbance, major with severe psychia MDS (Minimum Da assessment references resident as having deficits and severe making skills. Und assessed as not expensive or potent And that the reside rejection of care. Rextensive assistant (activities of daily live.	ses to include but not limited nentia without behavioral depressive disorder, recurrent atric symptoms. The current at Set) a quarterly with an ance date of 7/10/19 coded the long and short term memory ly impaired daily decision er behaviors the resident was chibiting any physical or verbalcial indicators for psychosis. In the was not exhibiting any esident #121 required be of two staff for ADL care wing) to include toileting needs one. The resident was for bathing.				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495277	B. WING _		C 08/08/2019
20 20 00 00 120 00 00 00 0	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	1 33/33/23/3
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 758	Continued From pa	age 61	F 75	58	
	Care Plan identifier potential for injury medications as ordepressive disorder include any individing or non-pharmacolor prevent/minimize Lato or during the processive dispersive to a tablet by mout hours for anxiety. For this psychotrop received a PRN do a.m., and another without non-pharmadministration. The documented as hit	Imprehensive Person Centered of psychotropic drug use as a related to the use of these dered for anxiety, and major er. The approaches did not ualized behavioral interventions ogical approaches to usage of as needed Ativan prior ovision of care. 9 Medication Administration is an order for Ativan 1 milligram th PRN (as needed) every eight There was no 14 day stop date in its drug order. The resident ose of Ativan on 8/1/19 at 9:13 dose on 8/5/19 at 9:15 a.m., hacological interventions prior to be behaviors for the Ativan were sting, kicking, scratching, and DL (activities of daily living)			
	July 2019 evidence administered Atival implementation of approaches prior to behaviors as follow June 9th at 8:09 a attempting to get usually 12th at 12:50 scratching, grabbing July 10th at 9:43 and grabbing	.mcombative with staff, up without assistance Da.mhitting, kicking,			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			32 - 61	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		495277	B. WING			C /08/2019	
	PROVIDER OR SUPPLIER	юх		STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		332010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	그 사이 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그 그	SHOULD BE	(X5) COMPLETION DATE	
F 758	(activities of daily ling July 23rd at 8:29 a out of bed, pacing July 24th at 10:31 scratching, grabbing July 27th at 10:14 scratching, cursing July 28th at 9:58 and grabbing, combative July 29th at 9:38 and grabbing, combative July 30th at 10:13 scratching, grabbing July 31st at 9:15 and grabbing, combative Who had address who ha	ving) .mresident attempted to get the hallway a.mhitting, kicking, a.mhitting, kicking, a.mhitting, kicking, c.mhitting, kicking, scratching, we during care .mhitting, kicking, scratching, we during ADL care a.mhitting, kicking, ag, cursing mhitting, kicking, scratching, mhitting, kicking,	F 7	758			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C
	PROVIDER OR SUPPLIER	ox		STREET ADDRESS. CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	08/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 758	Continued From pa	ge 63	F 7	58	
	documentation to enon-pharmacologic implemented or had administration of Pf fourteen doses admittrough August 5, 2 On 8/8/19 at 3:00 p meeting the above Administrator and the Interventions should physician order. Wattached, she stated The facility policy tit revised December 2 psychotropic drugs non-pharmacologic administration of a No additional informexit. Residents are Free CFR(s): 483.45(f)(2) The facility must en §483.45(f)(2) Residented in the Intervention of a lead of the Intervention of the Interven	RN Ativan for fourteen of hinistered from June 9, 2019 019. .m., during the pre-exit findings was shared with the ne Director of Nursing (DON). It non-pharmacological have been attached with the hen asked if they were d, "No." Iled Antipsychotic Medications 2016 addressed PRN however, it did not address al approaches prior to the PRN psychotropic. Ination was provided prior to of Significant Med Errors	F-7	F760 Corrective Action(s): Resident #128's attending physicibeen notified that the facility admit the incorrect dose of Humalog ins 8/6/19. A facility medication erro has been completed for this incide RN # 2 has received one on one exergarding medication administration which included a focus on the accurate administration of sliding scale instructions.	inistered ulin on r form nt. lucation on urate

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	42420000000		CONSTRUCTION		E SURVEY IPLETED
		495277	B. WING				C 08/2019
NAME OF S	PROVIDER OR SUPPLIER	1932.		STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 001	00/2019
INDINE OF F	TO VIDER OR SOLT EIER				B HOSPITAL ROAD		
HERITAC	E HALL NASSAWAD	OX					į
				NAS	SSAWADOX, VA 23413		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE RIATE	(X5) COMPLETION DATE
	-		1	T	Identification of Deficient Practice	(s)	
F 760	Continued From pa	nge 64	F 7	60	and Corrective Action(s):	1000001 1 0100	1
	Oomanded From pe	.95 5 1	1 9	00	All other residents receiving sliding	scale	
	The findings includ	od:			insulin may have potentially been	.	ì
	The findings includ	ea:		į	affected. A 100% audit of all residen with sliding scale insulin orders will		
	D==:d==+ #400==	a alacitta el tente fencilita e en			conducted to identify residents at ris		
		admitted to the facility on	5	\$0	residents identified at risk will be	V. 7 VII	
		most recent readmission on	Ĭ	F)	corrected at time of discovery and		1
		esident was placed on hospice	1		appropriate disciplinary action and		n.
		9. The diagnoses included, but 2 diabetes mellitus with		1	inservice training will be administered	ed as	
			1	5/0	warranted. An Incident and Accident	form	
	morbid obesity.	y, pseudocyst of pancreas, and			will be completed for each negative		
	morbid obesity.				finding.		
	Resident #128's m	ost recent MDS (minimum			Systemic Change(s):		
		ent was a 14 day scheduled			The facility policy and procedure ha	5	I
		n ARD (assessment reference	1		been reviewed and no changes are		
		sident #128 was coded as	'		warranted at this time. All Licensed		
		nitive function scoring 15 out of	I		Nursing staff will be inserviced on t		2.
		BIMS (brief interview for			facility policy and procedure by the	DON	
	mental status) exa				regarding the administration of		8
	I I dende van bestraamske manaa				medications per physician orders to include the proper administration of		İ
	A review of Reside	nt #128's comprehensive care			sliding scale insulin per physician or		
	plan dated 8/1/2019	9 revealed, in part, the	i.	100	situting scale insutin per physician of	uci,	
		tation: "Problem / Need. Risk			Monitoring:]
		emia (high/low blood sugar) r/t		8	The Director of Nursing is responsib		
		s. (Resident #128) will remain			maintaining compliance. The DON a designee will perform 2 random week		ĩ
		tions associated with Diabetes			Medication Pass audits to monitor for	-	
		v. Approaches include:			compliance. Any negative findings		
		dered; Monitor intake and	Ĭ	E	addressed at the time of discovery a		
		compliance; Monitor for thirst,		8	appropriate disciplinary action taker		J.
		, and excessive voiding;			Detailed findings of these results wi	ll be	
		rs as ordered and notify MD			reported to the Quality Assurance		İ
		er order; Administer	Ţ	1	Committee for review, analysis, and		
	medications as ord	erea.			recommendations for change in faci	nty	
	A == 4 D = -*		Ì		policy, procedure, and/or practice. Completion Date: 9/20/19		
		nt #128's physician orders,			Completion Date: 7/40/17		iš.
		evealed, in part, the following					10 S
	order related to the	treatment of diabetes:					
		nits/ml. Generic: Insulin Lispro		## ##			
	Kwikpen inject sub	g (subcutaneous) ac (with	4				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	52 64	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	08/08/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT 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 APPROPI DEFICIENCY)	BE COMPLETION
F 760	100-125=2u (units 126-200=4u 201-249=6u 250-299=8u 300-349=10u 350-400=12u >401=14u" Review of Reside medication admin that on 8/6/19, Relevel measured 16 10 units of sliding extra units of insu Further review of revealed no negar practice. Residem 171 at 11:30 a.m. On 8/8/19 at 11:30 conducted with Relevel measured 16 11:30 a.m. On 8/8/19 at 11:30 conducted with Relevel measured 16 11:30 a.m. On 8/8/19 at 11:30 conducted with Relevel measured 16 11:30 a.m. On 8/8/19 at 11:30 conducted with Relevel measured 16 11:30 a.m. On 8/8/19 at 11:30 conducted with Relevel measured 16 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m. On 8/8/19 at 11:30 a.m.	edtime) per sliding scale: int #128's August 2019 istration record (MAR) revealed sident #128's blood glucose 33 at 7:30 a.m The nurse gave scale insulin which resulted in 6 lin being administered. Resident #128's clinical record tive outcome from this deficient #128's blood sugar measured #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar #128's blood sugar	F 760		
		oximately 2:20 p.m., a phone ducted with other staff member			1

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495277	B. WING			08/2019	
	PROVIDER OR SUPPLIER GE HALL NASSAWAD	юх		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413			
(X4) ID PREF:X TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 760	would be any negal administering 10 uritions that the come hypoglyce. There was no recominutes after the all Humalog on 8/6/20 On 8/8/19 at 3:18 producted with additional composition of the individual admired the reside of the resident of the reside of the residence of the residen	rmacist. When asked if there tive side effects for nits, vs the ordered 4 units of od sugar of 163, OSM #5 not that high, should have as after administration, could mic. A significant med error." Independent of a blood sugar check 30 dministration of 10 units of 19. Independent of 10	F 760				

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495277	B. WING		08/0) 8/2019
	PROVIDER OR SUPPLIER	ox	g	TREET ADDRESS, CITY, STATE, ZIP CODE 468 HOSPITAL ROAD IASSAWADOX, VA 23413	1 00/0	3,2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION;	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIES (CROSS-REFERENCE)	D BE	(X5) COVPLETION DATE
F 760	drug was administe f. Any results achi were observed; and	ninistration; e (if applicable); or symptoms for which the ered; eved and when those results d nd title of the person	F 760			
	analog indicated to adults and children information was ob Institutes of Health. https://dailymed.nlm	rapid acting human insulin improve glycemic control in with diabetes mellitus. This tained from The National n.nih.gov/dailymed/drugInfo.cf-0e22-4fc7-a503-faa58c1b6f3f				
	edition documents Alert: Insulin -relate resulted in patient I dose, and expiratio nurseToxicity and manifested by sym hypoglycemia may glucose. Severe hy life-threatening em IV (intravenous) glu epinephrinesymp (anxiety; restlessne or tongue; chills, co pale skin; difficulty drowsinessrapid unsteady gait." Food Procurement	ergency; treatment consists of acose, glucagon, or toms of hypoglycemia ess; tingling in hands, feet, lips old sweats, confusion, cool, in concentration; heart rate, tremor, weakness, Store/Prepare/Serve-Sanitary	F 812			
	CFR(s): 483.60(i)(1 1012	¥		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	C 188	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495277	B. WING _		C 08/08/2019
NAME OF F	PROVIDER OR SUPPLIER	the state of the s		STREET ADDRESS, CITY, STATE, ZIP CODE	
LICDITAC	SE LIALE ALACCAMIAD	ov		9468 HOSPITAL ROAD	
DERITAG	GE HALL NASSAWAD	UX		NASSAWADOX, VA 23413	
(X4) ID		TEMENT OF DEFICIENCIES	GI	PROVIDER'S PLAN OF CORRE	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOOLS OF THE APP CROSS-REFERENCED TO THE APP DEFICIENCY)	
F 812	Continued From pa	ge 68	F 81		
			İ	F812	
	§483.60(i) Food sat	fety requirements.		Corrective Action(s):	
	The facility must -		•	The open container of ham with written on the container and the	1 2 dates
	5400 00(1)(4) D			half full container of Tomato Ju	ice was
		cure food from sources	8	removed from the reach-in refri	gerator
	state or local autho	ered satisfactory by federal,	er F	and disposed of. A facility Incid	lent and
		food items obtained directly		Accident form was completed f	or this
	from local producer	s, subject to applicable State		incident.	
	and local laws or re			The two metal ceiling vents ove	-44-6-1
		oes not prohibit or prevent	la de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	prep area that were accumulatin	tr the 100g
	facilities from using	produce grown in facility		condensation have been replace	d with
		compliance with applicable	H	plastic ceiling vents to reduce	
	safe growing and fo	ood-handling practices.		condensation building up, the th	ermostat
	(iii) This provision d	loes not preclude residents		control now has a locking cover prevent the staff from adjusting	to
	from consuming for	ods not procured by the facility.		temperature down and increasing	or the
			t:	condensation in the kitchen. The	tray line
	§483.60(i)(2) - Stor	e, prepare, distribute and		prep area has been reviewed and	tray cart
		dance with professional		locations have been adjusted to r	prevent
	standards for food s		NI .	carts from being under the ceilin	g vents in
	by:	NT is not met as evidenced	ľ	the kitchen. A facility Incident a Accident form was completed fo	nd
		ion, staff interview, and facility		incident.	r inis
3		was determined that facility		Identification of Deficient Prac	tices &
	staff failed to store	and prepare food in a sanitary		Corrective Action(s):	ß
	manner in the facilit			All other residents may have been	n
1		where dispressional		potentially affected. The Food Se Manager, and/or Registered Dieti	rvice
	The findings include	ed:		randomly monitor the kitchen pre	cian Will
			ic m	area before, during and after mea	ls to
	On 8/4/19 at 12:40	p.m., observation of the facility		identify any negative findings. The	ne
	kitchen was conduc	eted. On 8/4/19 at 1:10 p.m.,		freezers and refrigerators in the k	itchen
		of ham was found in the		will be monitored daily for proper	r storage
į	reach-in retrigerator	r. The open date labeled on		of food items. Any expired food of unlabeled or undated food items i	or dentified
		n documented "7/22/19." A		in the kitchen freezers, refrigerato	uentined
Ĭ	second date on the	container of ham documented		storage area will be corrected at ti	me of i
	"7/26/19. "		ñ	discovery and appropriate discipli	narv
	On 9/4/10 at 1:10 =	m a mitahan that balf	70 10 27	action taken as needed. A facility	Incident
<u></u>	way full of tomato ju	.m., a pitcher that was half lice was also observed in the		and Accident form will be comple each negative finding identified.	eted for

F 812 Continued From page 69 reach in refrigerator. "7/27/19" was the date labeled on the pitcher. On 8/4/19 at 1:11 p.m., an interview was conducted with OSM (other staff member) #7, the cook. When asked about the second date labeled on the ham, OSM #7 stated that the 7/26/19 date was the use by date and that the ham should have been thrown away. OSM #7 then threw the container away. When asked about the tomato juice, OSM #7 stated that it was probably made that day and would be used by the end of the day. When asked why the date on the pitcher documented "7/27/19," OSM #7 stated that the wrong date must have been written on the pitcher. OSM #7 could not say for certain if the tomato juice was new or old. On 8/6/19 at 10:10 a.m., a second observation of the facility kitchen was conducted. Two vents in the ceiling were observed over the food prep station. The vents were accumulating condensation from the A/C (air conditioning) units. Water droplets were also observed dripping from the second vent onto the food rack that contained trays of sandwiches. The sandwiches were also covered in plastic wrap. Unidentified black spots were observed on the vents. There was also a puddle of water observed on the floor underneath the food tray rack.		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	200 200 200 200 200 200 200 200 200 200	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
HERITAGE HALL NASSAWADOX (ALL) (ALL			495277	B. WING		2000
FREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 812 Continued From page 69 reach in refrigerator, "7/27/19" was the date labeled on the pitcher. On 8/4/19 at 1:11 p.m., an interview was conducted with OSM (other staff member) #7, the cook. When asked about the second date labeled on the ham, OSM #7 stated that the 7/26/19 date was the use by date and that the ham should have been thrown away. OSM #7 then stated that the ham was either old or staff labeled the wrong dates on the container. OSM #7 then threw the container away. When asked about the tomato juice, OSM #7 stated that it was probably made that day and would be used by the end of the day. When asked why the date on the pitcher documented "7/27/19," OSM #7 stated that the pitcher. OSM #7 could not say for certain if the tomato juice was new or old. On 8/6/19 at 10:10 a.m., a second observation of the facility kitchen was conducted. Two vents in the ceiling were observed over the food prep station. The vents were accumulating condensation from the A/C (air conditioning) units. Water droplets were also observed dripping from the sccond vent onto the food rack that contained trays of sandwiches were also covered in plastic wrap. Unidentified black spots were observed on the vents. There was also a puddle of water observed on the floor underneath the food tray rack.			юх		9468 HOSPITAL ROAD	, 00/00/2010
reach in refrigerator. "7/27/19" was the date labeled on the pitcher. On 8/4/19 at 1:11 p.m., an interview was conducted with OSM (other staff member) #7, the cook. When asked about the second date labeled on the ham, OSM #7 stated that the 7/26/19 date was the use by date and that the ham should have been thrown away. OSM #7 then stated that the container away. When asked about the tomato juice, OSM #7 stated that it was probably made that day and would be used by the end of the day. When asked why the date on the pitcher documented "7/27/19," OSM #7 stated that it was probably made that day and would be used by the end of the day. When asked why the date on the pitcher documented "7/27/19," OSM #7 stated that the ham was end to the pitcher. OSM #7 could not say for certain if the tomato juice was new or old. On 8/6/19 at 10:10 a.m., a second observation of the facility kitchen was conducted. Two vents in the ceiling were observed over the food prep station. The vents were accumulating condensation from the A/C (air conditioning) units. Water droplets were observed coming off the first vent and onto a tray full off hot dog buns. The tray was covered in plastic wrap. Water droplets were also observed dripping from the second vent onto the food rack that contained trays of sandwiches. The sandwiches were also covered in plastic wrap. Unidentified black spots were observed on the vents. There was also a puddle of water observed on the floor underneath the food tray rack.	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	(EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPRO	ILD BE COMPLETION
On 8/6/19 at approximately 10:15 a.m., an interview was conducted with OSM (other staff member) #8, the maintenance director. When		reach in refrigerato labeled on the pitch on 8/4/19 at 1:11 producted with OS cook. When asked on the ham, OSM is was the use by dat have been thrown the ham was either dates on the container away. We juice, OSM #7 stat that day and would when asked why the documented "7/27/wrong date must he pitcher. OSM #7 container away in the facility kitchen the ceiling were obstation. The vents condensation from units. Water droplets were also second vent onto the tray was covered in plastic were observed on puddle of water obstation. On 8/6/19 at approinterview was confined to the food tray rack.	or. "7/27/19" was the date ner. o.m., an interview was iM (other staff member) #7, the about the second date labeled #7 stated that the 7/26/19 date e and that the ham should away. OSM #7 then stated that rold or staff labeled the wrong iner. OSM #7 then threw the hen asked about the tomato ed that it was probably made I be used by the end of the day. He date on the pitcher (19," OSM #7 stated that the ave been written on the ould not say for certain if the new or old. If a.m., a second observation of was conducted. Two vents in observed over the food prepowere accumulating in the A/C (air conditioning) ets were observed coming off onto a tray full off hot dog buns. The sandwiches were also wrap. Unidentified black spots the vents. There was also a observed on the floor underneath observed with OSM (other staff or the sandwiches were staff or the sandwiches were staff or the sandwiches were also wrap. Unidentified black spots the vents. There was also a observed with OSM (other staff or the sandwiches were also wor the sandwiches were also wor the sandwiches were also wor the vents. There was also a observed with OSM (other staff or the sandwiches were also wor the sandwiches were als		kitchen for condensation and proper maintenance of the temperature in k area to prevent condensation building. Systemic Change(s): Current facility policy & procedure been reviewed and no changes are warranted at this time. The Dietary Manager will inservice the dietary so the proper preparing, storing and distribution of food under sanitary conditions, to include ensuring all e foods items are removed from distriand that the temperatures are in the appropriate range for the refrigerator freezer. All Dietary staff will be inserviced revised layout of the tray line prepaup area for proper meal tray set up is sanitary fashion. Monitoring: The Dietary Manager and the DON responsible for maintaining complianten Dietary food storage audit tool daily monitor for compliance. Any negatifindings will be corrected at time of discovery and disciplinary action we taken as warranted. The maintenance will perform weekly Kitchen audits monitor for compliance with condeand temperature in the kitchen. Any negative findings will be corrected of discovery and disciplinary action be taken as warranted. The results of audits will be reported to the Qualit Assurance Committee for review, analysis, & recommendations for chin facility policy, procedure, and/or	has taff on xpired bution r and on the and set n a are ance. the y to ive ill be ee staff to insation at time a will of these y nange

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED C	
		495277	B. WING		08/08/2019
	ROVIDER OR SUPPLIER	ох		STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	DDE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEVENT OF DEFICIENCIES V 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 COMPLETION
F 812	coming from, OSM condensation was conditioner. OSM # kitchen like to turn harder. OSM #8 stadining room and kit times making the A stated it was currer the kitchen but at tit thermostat in the 5 placed a sign up in touch the thermost the vents should be OSM #8 stated thawhy water from the on the food trays, 0 want water on my from the vents were, OS know. When asked again that he didn't On 8/6/19 at 10:20 conducted with OS When asked how I water, OSM #9 staor "any mind" to the sure how long the that." On 8/8/19 at 3:18 pmember) #1, the A ADON (Assistant Daware of the above information was princed the sure how long the sure formation was princed the sure how long the sure formation was princed the sure how long the sure formation was princed the sure how long the sure formation was princed the sure how long the sure formation was princed the sure formation	modensation on the vents was #8 stated that the coming from the air 8 stated that the staff in the up the A/C causing it to work ated that the door between the chen was also kept open at A/C unit work harder. OSM #8 htly 68 degrees (Fahrenheit) in mes he will notice the 0's. OSM #8 stated he had the kitchen asking staff to not at. When asked if water from a dripping on the food trays, it is should not. When asked it vents should not be dripping DSM #8 stated, "I wouldn't ood." When asked if the water clean, OSM #8 stated that he asked what the black spots on is M #8 stated that he didn't it it was mold, OSM #8 stated			

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 71 of 79

RECEIVED

AUG 30 2019

PRINTED: 08/19/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING ____ 495277 B. WING 08/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD HERITAGE HALL NASSAWADOX NASSAWADOX, VA 23413 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 1D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 812 | Continued From page 71 F 812 Food," documents in part, the following: "Refrigeration Storage: 1. All foods must be covered, labeled and dated with a date label. All food should be monitored each day to be assured that the foods will be used, consumed, or discarded by the use by date or expired date...All leftover food (previously prepared on site) food must be used or discarded within 3 days. The count begins the day the food was prepared. 4. All food items that are not secured in their original containers must be stored in closed containers and secured. The label must identify the common name of food, if food cannot easily be identified. The label must have the date the food was packaged, received or prepared and/or an expiration date. Expiration dates may be used or the food storage chart guideline may be used to determine the expiration date."

Complaint Deficiency.

F 814 Dispose Garbage and Refuse Properly SS=E | CFR(s): 483.60(i)(4)

§483.60(i)(4)- Dispose of garbage and refuse properly.

This REQUIREMENT is not met as evidenced

Based on observation, staff interview and facility document review, it was determined that facility staff failed to maintain the facility dumpster in a manner to prevent pests for one of two facility dumpsters.

The findings included:

On 8/4/19 at 1:15 p.m., observation of the facility dumpster was conducted with OSM #7, the cook. One of two facility dumpsters had the doors open

F814

F 814

Corrective Action(s):

The area around the dumpsters was cleaned and all the dumpster doors were closed. A Facility Incident & Accident Form has been completed for this incident.

Identification of Corrective Deficient Practice(s) & Corrective Action(s): All other garbage disposal and storage

areas have the potential to be affected. The Maintenance Director and Environmental Services Director will inspect all garbage storage areas to identify risk. Any/All negative findings will be corrected at time of discovery.

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	COOK TOWNS COME TO SERVICE STREET	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
NAME OF	PROVIDER OR SUPPLIER		L	STREET ADDRESS, CITY, STATE, ZIP CODE	
147.00,2 01	THO VIDELY OF TOO! I EIEN		- 4	9468 HOSPITAL ROAD	-
HERITAC	GE HALL NASSAWAD	OX			
	<u> </u>			NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENC	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION
F 814	dumpster was over who was responsite dumpster; ensuring surrounding debris (all staff) should maked why the dumpsted to prevent pespecially the feral the area. OSM #7 was not shut. On 8/8/19 at 3:18 pmember) #1, the AADON (Assistant Eaware of the above	inge 72 ck of the dumpster. The full with trash. When asked the for maintaining the facility it was shut and free from the confirmed that everyone aske sure the dumpsters are unding area was clean, but that etary's responsibility. When the poster should be shut, OSM #7 the ests from getting into the trash cats that have been spotted in confirmed that the dumpster should that the dumpster that the dumpste	F 814	Systemic Change(s): The facility policy & procedure for storage and disposal of refuse was reviewed and no changes are warn this time. The Maintenance Direct and/or Environmental Services di will provide in-services to all staff proper techniques for the collectic storage, and disposal of refuse. The inservice training will include dist of all refuse inside supplied dump. Monitoring: The Environmental Services Director responsible for maintaining comp. The Maintenance Director and/or Environmental Services Director complete rounds of dumpster area weekly to monitor and maintain compliance. Any negative finding corrected immediately. The result these rounds will be reported to the Quality Assurance Committee for analysis, & recommendations for	ranted at ctor rector f on the con, he posing osters. ctor is cliance. will as case will be ts of he review,
F 880 SS≂D	Refuse," documen "Refuse containers the facility should he should be covered Dumpster should be facility contract; ga or be left outside the Infection Prevention CFR(s): 483.80(a)(§483.80 Infection CThe facility must estimate infection prevention designed to provide comfortable environted.	n & Control 1)(2)(4)(e)(f) Control Stablish and maintain an and control program e a safe, sanitary and ment and to help prevent the cansmission of communicable	F 880	in facility policy, procedure, and/opractice. Completion Date: 9/20/19 F880 Corrective Action(s): LPN #1 involved in the Treatment Observation for Resident's #12 has received one-on-one inservice train	s ning on o be . A was inage been

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 73 of 79

RECEIVED

AUG 30 2010

STATEMENT	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/YOU MUIL	TID! E C	CONSTRUCTION	or of the	. 0930-0351
	OF CORRECTION	IDENTIFICATION NUMBER:	The second second				TE SURVEY MPLETED
			A. BUILDI		77 77 77		
		405277	B. WING				С
NAME OF	DOUBLE OF CHES	495277	B. WING			08.	/08/2019
NAME OF	PROVIDER OR SUPPLIER		ŀ	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE HALL NASSAWAD	ΟX		9468	HOSPITAL ROAD		
		•··		NAS	SSAWADOX, VA 23413		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(YE)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	x j	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION
TAG	NEGOLATORI OR L.	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				7			
E 000				İ	Identification of Deficient Practice(s) &	
F 880	Continued From pa	ge 73	F 8	80	Corrective Action(s):		
	*			*	All other residents who receive a dres change and all residents who have fol		
	§483.80(a) Infection	prevention and control		į	catheters may have potentially been	c y	
	program.			Î	affected.		:
	The facility must es	tablish an infection prevention		ł	The DON, ADON and/or Unit Manag	er	
	and control progran	n (IPCP) that must include, at			will conduct a 100% audit of all dress		
	a minimum, the folk	owing elements:		Ť	change treatments on all licensed nurs		16
				ļ	staff to observe proper infection contr		8
	§483.80(a)(1) A sys	tem for preventing, identifying,		18	practices and proper hand washing du	ring	i
	reporting, investigat	ing, and controlling infections			the treatment pass administration	or cons	
	and communicable	diseases for all residents,		i.	procedures. Any negative findings wi addressed immediately, and discipling		30.
		sitors, and other individuals		İ	action taken as needed. A facility Inci	iry dant	
	providing services u			ļ	and Accident form will be completed	for	
		upon the facility assessment			each negative finding.	101	
	conducted accordin	g to §483.70(e) and following		Į	The infection preventionist will condu	ict a	į.
	accepted national s				100% audit of all residents with foley		
		9		į	catheters to determine those at risk. A	iny	
	§483.80(a)(2) Writte	en standards, policies, and		37	negative findings will be addressed		
	procedures for the	program, which must include,			immediately, and disciplinary action		
	but are not limited to				taken as needed. A facility Incident ar		
	(i) A system of surve	eillance designed to identify		1	Accident form will be completed for onegative finding.	ach	
	possible communic	able diseases or		*	negative intuing.		
	infections before the	ey can spread to other		Į.	Systemic Change(s):		
	persons in the facili	ty;			The facility policy and procedures have	/e	i4 3
		om possible incidents of			been reviewed and no changes are		
	communicable dise	ase or infections should be		1:	warranted at this time. All licensed sta		
	reported;	i			will be inserviced on the facility police		
	(iii) Standard and tra	ansmission-based precautions		Î	and procedure for proper infection co		
		event spread of infections;			practices during treatment procedures when foley catheters are in use by the		
	(iv)When and how i	solation should be used for a			DON and/or Regional Nurse Consulta	ent	
	resident; including b			Ţ)	DON and/or regional Nuise Consum	u11.	
390	(A) The type and du	ration of the isolation,		Ī	Monitoring:		
		infectious agent or organism			The DON is responsible for maintaini	ng	
90	involved, and			Ě	compliance. The DON, Unit Manager		3
5.00		nat the isolation should be the		Į.	and/or designee will perform 2 randor		
	least restrictive pos-	sible for the resident under the			weeklyTreatment Pass audits to moni-	or	
	circumstances.			ī	nursing staff for compliance. The	•	
		es under which the facility		f .	infection preventionist will conduct v		
	must prohibit emplo	yees with a communicable		8	audits 3 times weekly of all residents		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		60 1050	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495277	B. WING _		08/08/2019
	PROVIDER OR SUPPLIER	ox		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APP DEFICIENCY)	OULD BE COMPLETION
F 880	disease or infected contact with reside contact will transmi (vi)The hand hygiel by staff involved in §483.80(a)(4) A sysidentified under the corrective actions to §483.80(e) Linens. Personnel must ha transport linens so infection. §483.80(f) Annual The facility will con IPCP and update to IPCP a	skin lesions from direct of the or their food, if direct of the disease; and the procedures to be followed direct resident contact. In the disease; and the procedures to be followed direct resident contact. In the facility's IPCP and the the the aken by the facility. In the store, process, and the as to prevent the spread of the review. In the spread of the their program, as necessary. In the survey and the their program, as necessary. In the survey sample. For the their program in the survey sample. For the spread to perform the facility staff failed to	F 88	Findings of the audits will be reported the QA Committee for review, an and recommendations for change facility policy, procedure, and/or Completion Date: 9/20/19	alysis, in
3	The Quarterly Revi	sion Minimum Data Set (MDS)	·		

		& MEDICAID SERVICES			FOR	MAPPROVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	/Y2\ MLB		Contract to the Contract to th	O. 0938-0391
	OF CORRECTION	IDENTIFICATION NUMBER:	1 000MS 000	ING		ATE SURVEY OMPLETED
		495277	B. WING	8		C 8/08/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		0,00,2015
HERITAG	E HALL NASSAWAD	οx		9468 HOSPITAL ROAD		-
				NASSAWADOX, VA 23413		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORE		(X5)
PREFIX TAG	프라 프라마트 1 30 HH 라스타니라 급하드라드리드 2 1 HH	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	**** ****		COMPLETION DATE
F 880	Continued From pa	ge 75	, E0	380	600000 50	
		assessment reference date	, ,,	180		4
Ĩ		coded the resident as having	Î			i
S		term memory problems.		7		Ī
	In section "G" (Phys	sical functioning) the resident	20	,		
	was coded as need		ł			į
		oility, limited assistance with	r			Ĩ
7		on with locomotion, limited		10		i
į		ssing, limited assistance with	Ĭ	1		
	toileting, personal h	physical assistance with	f	,		
İ	tolleting, personal in	ygierie and balling.	l i			1
	On 08/07/19 at app	roximately 9:48 AM Resident	E			
		wound care to his right heel by	İ	ī		
Ĩ		ctical Nurse) #1. As she				
		kerlix dressing the resident's	ii.	ļ		
ļ.		the resident's bed sheet. LPN ident #12 if he was ok, he				I i
		ceived assistance from CNA	į.			į.
		resident's right foot She then	Ĭ			
ļ		nis right heel wound without				
	difficulty.	20 -3				
ļ	0 0/07/40		Î	I		
!		eximately 10:10 AM with LPN	Į.			10
į		bove issue. She stated been a pad placed under him		Ţ		
1	when I removed the	dressing and should have		I		
	placed a pad under					1
ļ	A review of physicia	n orders read as follows:		*		J.
		vound with DWC pat dry,		ì		Į.
i		kins moistened gauze wrap	No.	N		Street Street
		uze every day and as needed.				
ĺ	On 00/00/40 -+					
	Un U8/U8/19 at app	proximately 4:22 PM an ucted with LPN #10. She was		15 25		100 mm
		oviding wound care on a				6
		would she proceed with it? "I				

would have someone assist me to elevate the

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/19/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495277	B. WING		C 08/08/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NASSAWADOX				STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	1 00/00/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOCK CROSS-REFERENCED TO THE APPROPRIES (ENCY)	JLD BE COMPLÉTIO	NC
F 880	Wound Care Policy provide guidelines of promote healing. Pequipment and sup and Supplies: Disposteps in the Proceed Place disposable of wound) to serve as linen and other book on 08/08/19 at appresent interview wo DON and Administrate. 2. Resident # 129 of facility for skilled sefall at home resulting then readmitted on with diagnosis of Fourier Tract Infection (UT neurogenic bladder and dementia. The assessment reference resident as having deficits and severe daily decision making an indwest the resident #129 of at risk for injury relating the resident removes the removes the rem	r: Purpose: The purpose is to for the care of wounds to reparation: Assemble the plies as needed. Equipment osable cloths, as indicated. dure: #3 Position resident. to heart to resident (under the a barrier to protect the bed	F8	80		
	did not include app	roaches to handle the tubing	ļ			

PRINTED: 08/19/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _____ 495277 B. WING 08/08/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD HERITAGE HALL NASSAWADOX NASSAWADOX, VA 23413 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 880 | Continued From page 77 F 880 or Foley drainage bag in a manner to prevent catheter-associated urinary tract infections. 08/4/19 at 4:04 p.m., observed during the initial tour and again on 8/5/19 at 10:26 a.m., 11:43 a.m., 1:12 p.m. and 1:33 p.m. the Foley drainage bag was attached to the side of the bed, the bed was being maintained in the low position due to the resident's fall risk, the drainage bag and tubing were observed on the floor. On 8/6/19 at approximately 9:15 a.m., and 4:00 p.m., the resident was observed in bed in low position with the Foley catheter tubing and drainage bag on the floor. On 8/7/19 at 9:50 a.m., the resident was observed in a wheelchair being transported to the rehab therapy room by the private sitter. The Foley bag was observed to be in contact with the floor during the transport. At 4:06 p.m., the resident was observed sitting up in the wheelchair in front of the nurses station. The Foley drainage bag was attached under the wheelchair seat but not high enough to prevent it from making contact with the floor. On 8/8/19 at 10:13 a.m., the resident was observed asleep in bed, the Foley drainage bag and tubing were on the floor. At this time the right side unit manager was asked to come into the

room. When asked if the Foley catheter bag and tubing should be making contact with the floor she stated, "Absolutely not." When asked why, she stated, "Because of the germs." She then stated, "Thank you and I will take care of it."

On 8/8/19 at 3:00 p.m., during the pre-exit meeting the above findings was shared with the Administrator and the Director of Nursing.

The facility policy and procedure titled Catheter

PRINTED: 08/19/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 08/08/2019
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
Street on the district of the processing of the control of the con				9468 HOSPITAL ROAD	
HERITAG	IE HALL NASSAWAD	JOX	İ	NASSAWADOX, VA 23413	
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION
E 090	Carting and Francis	70		7	29
F 660	Continued From pa		F8	80	
	follows:	ed September 2016 read as	l L	1	į.
		ose of this procedure is to	į.	T .	
		ssociated urinary tract		ļ	1
	infections. Infection Control:		i	1	r c
		theter tubing and drainage bag or.	İ		Ï
	No additional inform	nation was provided prior to	İ		
	exit.	nation was provided prior to	I.	1	1
,					į
			E F	i	
		×	T.		
		,			
			L		
ļ					
					Í
			I I		e E
					į.
			L	1	3
			i İ		
			1		
			Î		
					j
			I.	Ĭ	
					T _k
			15	1	
					e* 180

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

Event ID: W1Y811

Facility ID: VA0116

If continuation sheet Page 79 of 79 RECEIVED

AUG 30 2019

VDH/OLC

	*	
		a
E.		