STATEMENT OF DEFICIENCIES

(X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 07/02/2019 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

IND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		СОМ	PLETED
æ		495320	B. WING				
	ROVIDER OR SUPPLIER			. 12	REET ADDRESS, CITY, STATE, ZIP CODE 25 CLINTWOOD MAIN STREET, ROUTE 607 PO E		3/20/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	iD PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
	survey 6/18/19 throug required for compliant Long Term Care requi Code survey/report w	0 certified bed facility was					
F 554 SS=D	consisted of 25 currer closed record reviews Resident Self-Admin CFR(s): 483.10(c)(7) §483.10(c)(7) The rigi medications if the intedefined by §483.21(b) this practice is clinical This REQUIREMENT by: Based on observation interview, clinical record document review, the 1 of 28 Residents in the self-administration of the self-administration o	Meds-Clinically Approp Int to self-administer redisciplinary team, as 1(2)(ii), has determined that Ily appropriate. Is not met as evidenced In, Resident interview, staff and review, and facility facility staff failed to assess the survey sample for safe medication, Resident # 45.	F	554	Correction Action(s): The nasal spray was removed from the resident's room on 6/19/19 and placed back on the medication cart. Resident #45 has been assessed using the Folstein Mini Mental Exam by the DON to determine if the resident is able to self-administer medication. It was determined that the resident is not able to self-administer his medications. A Facility Incident & Accident form was completed for this incident.		9.8
2024707	The facility staff failed safe self-administration. Resident # 45 was an was admitted to the fareadmission date of 1 but were not limited to hypertension, and typ	to assess Resident # 45 for on of medication. 89-year-old-female who acility on 6/9/15, with a /9/19. Diagnoses included on anxiety, anemia, e 2 diabetes mellitus.			RECEIVE JUL 1 6 201 VDH/OL	9	(X9) DATE

(X2) MULTIPLE CONSTRUCTION

by deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

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(X3) DATE SURVEY

ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING_		COMP	LETED
		495320	B. WING			06/:	20/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		20/2010
				12	225 CLINTWOOD MAIN STREET, ROUTE 607 PO E	3OX 909	
HERITAGE	HALL CLINTWOOD			C	LINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC !DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 554	MDS (minimum data a quarterly assessment reference date) of 4/1 assesses cognitive pathe facility staff documhad a BIMS (brief interscore of 4 out of 15, we Resident # 45's cognimpaired. Resident # 45 had ordered impaired. Resident # 45 had ordered impaired. Resident # 45 had ordered impaired. Resident # 45 had ordered impaired impaired impaired. On 6/9/19 at 10:38 and bottle of nasal salines is Resident # 45's over it in a compared impaired impaired. On 6/9/19 at 11:05 and Resident # 45's clinical and assessment that defended impaired impa	at 4:23 pm. The most recent set) assessment was a with an ARD (assessment 6/19. Section C of the MDS atterns. In Section C0500, mented that Resident # 45 erview for mental status) which indicated that tive status was severely ders that included but were 0.65% nasal spray inhale 1 BID (2 times daily) pm (as initiated by the physician on the surveyor observed a spray in a basket on bed table. In, the surveyor reviewed all record and did not locate etermined that Resident # Iminister medications. In, the surveyor interviewed arveyor asked Resident #45 spray that had been bed table. Resident # 45 thuse it no more than I have the surveyor interviewed ctical nurse). The surveyor ctical nurse in the surveyor interviewed ctical nurse). The surveyor	F	554	Identification of Deficient Practice(s) and Corrective Action(s): A 100% review of all resident rooms and bedside tables will be completed to check for medications that are being self-administered without assessment or a physician order by the DON, Unit Managers and/or designee. Any resident found to be self-administering medications without a physician order an an appropriate Folstein Mini-Mental Exam to determine their ability to safely and effectively self-administer medications will be corrected at time of discovery. The attending physician will be notified and a Folstein Mini-Mental Examill be completed to determine if it is clinically appropriate for the resident to self-administer medications. A facility Incident & Accident form will be completed for all negative findings. Systemic Change(s): The facility Policy and Procedure has been reviewed and no changes are warranted at this time. All licensed staff and the interdisciplinary team will be inserviced by the DON and/or regional nurse consultant on the policy and procedure for self administration of medications, assessment used for determining self-administration of medications, as well as documenting in the residents comprehensive care plan ar the need to obtain a physicians order for self administration of medications.	k dd	

(X2) MULTIPLE CONSTRUCTION

JUL 1 6 2019 VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495320	B. WING _		06	6/20/2019	
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CO 1225 CLINTWOOD MAIN STREET, RO CLINTWOOD, VA 24228	ODE		
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F 554	Medications" contains included but was not"Policy Interpretated 1. As part of their of and practitioner will a mental and physical a self-administering me appropriate for the reformas made aware of the self-administering me appropriate for the reformas made aware of the self-administering me appropriate for the reformas made aware of the self-administering me appropriate for the reformas made aware of the self-administering me appropriate for the reformation of the self-administering me appropriate for the reformation of the self-administering me appropriate for the	"Self-Administration of ed documentation that limited to, on and Implementation everall evaluation, the staff essess each resident's abilities to determine whether edications is clinically	F 5:	Monitoring: The DON is responsible for of The DON, Unit Managers, an nurse will review all docume communication daily for resi administering medications to medication was taken approphiscrepancies found in these corrected at time of discover reported to the Quality Assur Committee for review, analy recommendations for change policy, procedure, and/or procedure, and/or procedure to Date: 08/04/19	nd/or charge intation and dents self ensure oriately. All audits will be y and ance sis, and e in facility	E.	
F 583 SS=D	presented to the survice conference on 6/20/1 Personal Privacy/Cor CFR(s): 483.10(h)(1) §483.10(h) Privacy at The resident has a rigic confidentiality of his corecords. §483.10(h)(l) Persona accommodations, metelephone communicated meetings of familithis does not require private room for each §483.10(h)(2) The fact residents right to personate right to privacy in his written, and electronic the right to send and mail and other letters	ey team prior to the exit 9. Infidentiality of Records (3)(i)(ii) Ind Confidentiality. In to personal privacy and or her personal and medical In privacy includes dical treatment, written and ations, personal care, visits, y and resident groups, but the facility to provide a resident. It is in the personal treatment of the sonal privacy, including the for her oral (that is, spoken), to communications, including promptly receive unopened	F 54	F583 Corrective Action: Resident #18's privacy curta her and her roommate was pr surveyor notification of the i 6/19/19. A facility Incident & Accide completed for this incident. Identification of Deficient I Corrective Action(s): All residents may have been affected. A 100% observatio residents will be completed t privacy was being provided residents. Any residents ide being exposed during the au- corrected at time of discover involved will receive immed training. An Incident & Acci will be completed for any/all exposure	potentially an audit of all attituded as dit will be y and staff liste inservice ident Form		

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IAME OF PR	ROVIDER OR SUPPLIER		1	s	TREET ADDRESS, CITY, STATE, ZIP CODE	06/20/2019
			İ		225 CLINTWOOD MAIN STREET, ROUTE 607 PO I	3OX 909
(ERITAGE	HALL CLINTWOOD			i	LINTWOOD, VA 24228	
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TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE DATE
F 583	Continued From page		F	583	Systemic Change(s): The facility policy and procedure has	il v
	than a postal service.	red through a means other			been reviewed and no changes are warranted at this time. All staff will be	9
	8483.10(h)(3) The res	sident has a right to secure			inserviced by the DON, and/or Social	E .
ļ		onal and medical records.			Services director on Resident Personal	53
ļ		ne right to refuse the release			Privacy to include privacy for roommate	S.
ļ	of personal and medic				Monitoring:	를
	provided at §483.70(i))(2) or other applicable			The DON is responsible for compliance.	a l
	federal or state laws.				The DON, ADON and/or designee will	
	(ii) The facility must a	llow representatives of the			perform two weekly rounds for resident	Ŷ.
	Office of the State Lo	ng-Term Care Ombudsman			privacy on each unit in order to maintain	1
		's medical, social, and			compliance. Any/all negative findings	ž
	administrative records	s in accordance with State			will be corrected immediately and disciplinary action will be taken as	1.
	law.	<u> </u>	1		warranted. Aggregate findings will be	ŽÍ.
- 1		is not met as evidenced			reported to the Quality Assurance	*.
	by:				Committee for review, analysis, and	1
		n, Resident interview, and			recommendations for changes in policy,	
		ew, the facility staff failed to			procedure, and/or facility practice.	W.
		cy for 1 of 28 Residents in			Completion Date: 08/04/19	210
	the survey sample, Re	esident # 18.				
	The findings included	:				
200	The facility staff failed	to ensure privacy for				.
	_	he disrobed in her room.				
		71-year-old-female who was				
		the facility on 9/30/14, with a			&:	
		/29/18. Diagnoses included	-		*1	
	but were not limited to		}			:
	auditory hallucinations	s, and hypertension.				
	The clinical record for				€ 20	
Ì		at 5:59 pm. The most recent				
		set) assessment was a				
		with an ARD (assessment				
		/19. Section C of the MDS				
		atterns. In Section C0500,			,	1
	the facility staff docum	nented that Resident # 18				
M CMS-2567	7(02-99) Previous Versions Obs	plete Event ID:TOJN11	1	Fac	Ality ID: VA0109 If contin	uation sheet Page 4 of 3

(X2) MULTIPLE CONSTRUCTION

JUL 1 6 2019 VDH/OLC

STATEMENT OF DEFICIENCIES

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(X3) DATE SURVEY

ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING.	···	COMP	LETED
		495320	B. WING			06/	20/2019
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
UCDITACE	HALL CLINTWOOD			١ ٠	1225 CLINTWOOD MAIN STREET, ROUTE 607 PO	3OX 909	
HERITAGE	HALL CLINT WOOD	191			CLINTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 583	Continued From page	4	F	583	3		
		erview for mental status)	,				
84	score of 5 out of 15, v						
ý		tive status was severely	3.				: :
	reviewed on 4/2/19. Ta problem area for Re "Mood/Behavior/Psyc# 18 is noted to have which usually is not a noted to yell out and reducation & risks hav success d/t (due to) cat times to take clother monitors for risk of ex (diagnosis) depression agitation, ID (intellected delusional d/o (disord behaviors noted this rincluded but were not procedures prior to git calm manner, monitorial."	thotropic drug use: Resident a sad facial expression ltered with interaction she is nit/kick at staff with care, the been explained little tognitive level. She is noted the soff likes to be naked staff the sposing self she has dx the naxiety, psychosis, that disability) schizophrenia, therein hallucinations, no the review." Interventions the limited to, "Explain ving care, approach in a the facial/body lang (language) the becomes agitated allow town before cont tre, provide calm					
8:	Resident # 18 sitting of initial tour. The surve privacy curtain between roommate had not be	en Resident # 18 and her en pulled. The surveyor nt # 18 had only a brief and		•	**		
		n, the surveyor observed bed wearing only a brief.					
100	10.0	SOL	241				

(X2) MULTIPLE CONSTRUCTION



PRINTED: 07/02/2019 FORM APPROVED

	MENT OF REALITIAN S FOR MEDICARE & I	MEDICAID SERVICES				OMB NO	0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI			(X3) DATE SURVEY COMPLETED	
		495320	B. WING			06/2	0/2019
NAME OF PI	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE	O BOY OOD	
HERITAGE HALL CLINTWOOD					25 CLINTWOOD MAIN STREET, ROUTE 607 P LINTWOOD, VA 24228	O BOX 303	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 583	between Resident # not been pulled, and uncovered and her b roommate. On 6/18/19 at 5:57 p Resident # 18's roon surveyor asked Resi undressed often. Re see her get naked ex The facility policy on documentation that i to,"Policy Interpretati 1. Federal and sta basic rights to all res rights include the res t. privacy and confid On 5/19/19 at 5:30 p	ed that the privacy curtain 18 and her roommate had Resident # 18 was reast were visible to her m, the surveyor interviewed nmate Resident # 91.The dent # 91 if Resident # 18 sident # 91 stated, "Yes, I very day." "Resident Rights" contained included but was not limited on and Implementation te laws guarantee certain sidents of this facility. These sident's right to:	F	583			

F 645 PASARR Screening for MD & ID SS=D

CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for

No further information regarding this issue was provided to the survey team prior to the exit

individuals with a mental disorder and individuals with intellectual disability.

§483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)

(i) of this section, unless the State mental health

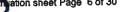
F 645

F645 Corrective Action(s)

Resident #52's attending physician and responsible party have been notified that the facility failed to obtain a level Π PASRR for the resident prior to their admission. A facility Incident & Accident form has been completed for this incident.

Facility ID: VA0109

Event ID: TOJN11



conference on 6/20/19.

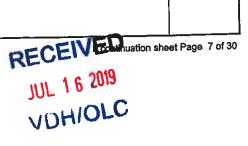
PRINTED: 07/02/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				(X3) DATE	. 0300-000 I
STATEMENT OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION	COMPLETED	
		495320	B, WING			06/	20/2019
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 25 CLINTWOOD MAIN STREET, ROUTE 607 PO		
HERITAGI	E HALL CLINTWOOD			CLINTWOOD, VA 24228			
(X4) ID PREFIX TAG	(FACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 645	authority has determindependent physical performed by a persistate mental health (A) That, because of condition of the individual services, whether the specialized services (ii) Intellectual disability authority has determ (A) That, because of condition of the individual services, whether the level of services and (B) If the individual services, whether the specialized services and (B) If the individual services, whether the specialized services \$483.20(k)(2) Excessection—(i)The preadmission paragraph(k)(1) of for determinations to a nursing facility being admitted to the transferred for care (ii) The State may preadmission screparagraph (k)(1) of to a nursing facility (A) Who is admitted	ained, based on an all and mental evaluation on or entity other than the authority, prior to admission, if the physical and mental vidual, the individual requires provided by a nursing facility; requires such level of the individual requires si; or aility, as defined in paragraph from unless the State or developmental disability mined prior to admission-of the physical and mental vidual, the individual requires a provided by a nursing facility; requires such level of the individual requires as for intellectual disability. The physical and mental vidual requires are individual requires as for intellectual disability. The individual requires of this are screening program under this section need not provide in the case of the readmission of an individual who, after the nursing facility, was an in a hospital. The choose not to apply the ening program under this section to the admission of this section to the admission.	F	645	Identification of Deficient Practices & Corrective Action(s): All other residents who were required to have a Level II PASRR prior to admission may have been affected. The social services director and/or Admissions director will complete a 100% review of all residents to identify residents who needed a level II PASRR completed prior to admission but did not have one. All negative findings will be corrected at the time of discovery by notifying the attending physician and responsible part A facility Incident & Accident form has been completed for each incident. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The admission director, social worker, DON, and administrator have been inserviced by the regional nurse consultant on the requirement that residents with a mental disorder have a Level II PASRR be completed prior to admission Monitoring: The social worker and admissions directly will be responsible for maintaining compliance. Potential new residents will be reviewed prior to their admission to ensure that a PASRR has been completed if indicated. Negative findings will be corrected at the time of discovery. Aggregate findings will be reported to QA Committee for review, analysis an recommendation for changes in facility policy, procedure and/or practice. Completion Date: 08/04/19	on f or e ty. he d the the d the	

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

Event ID: TOJN11

Facility ID: VA0109



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY APLETED	
		495320	B. WING				6/20/2019	
NAME OF PI	ROVIDER OR SUPPLIER	<u> </u>	!	STI	REET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL CLINTWOOD				25 CLINTWOOD MAIN STREET, ROUTE 607 .INTWOOD, VA 24228	' PO BOX 909		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE	
F 645	(B) Who requires nur condition for which the hospital, and (C) Whose attending before admission to the likely to require less facility services. §483.20(k)(3) Definition section— (i) An individual is condisorder if the individual disorder defined in 4 (ii) An individual is controllectual disability intellectual disability or is a person with a described in 435.101 This REQUIREMENT by: Based on staff interview, the facility staff sale passed on the facility staff faile staff faile staff and a Level II PA screening and resident # 52 was a admitted to the facility to the facility staff faile staff fa	sing facility services for the se individual received care in physician has certified, the facility that the individual is than 30 days of nursing sion. For purposes of this unsidered to have a mental ual has a serious mental 83.102(b)(1). Considered to have an if the individual has an as defined in §483.102(b)(3) related condition as 10 of this chapter. To is not met as evidenced wiew and clinical record aff failed to ensure that 1 of survey sample had a Level II \$52.	F	645		•		
46	Resident # 52 was a admitted to the facili included but were no disorder, depression. The clinical record for reviewed on 6/18/19	ent review). .74-year-old-female who was			15. 25.			

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
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		495320	B. WING			06/	20/2019
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 007.	2012013
				l	25 CLINTWOOD MAIN STREET, ROUTE 607 PO	BOX 909	
HERITAGI	E HALL CLINTWOOD			CL	INTWOOD, VA 24228		
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F 645		with an ARD (assessment	F	645			
	"Screening for Mental Retardation/Intellectu Conditions" form for F	al Disability, or Related Resident # 52. The surveyor en checkmark documented	6		a a		
	the facility social work 52 had a Level II PAS worker informed the s that were provided we the hospital had sent	n, the surveyor interviewed ter and asked if Resident # ARR. The facility social surveyor that the documents ere the only documents that with Resident # 52 when the she would check to see if a been completed.				*	
	informed the surveyor had a Level II PASAR	n, the facility social worker r that Resident # 52 had not R assessment. rm, the administrative team			. #		
	was made aware of the No further information presented to the survice conference on 6/20/19	regarding this issue was ey team prior to the exit			·		
F 684 SS=D	§ 483.25 Quality of ca Quality of care is a fur applies to all treatment facility residents. Base	ure indamental principle that it and care provided to ed on the comprehensive lent, the facility must ensure	F	684	F684 Corrective Action(s): Resident #66's attending physician wa notified that the facility staff failed to provide Restorative nursing services per physician order. A facility Incident & Accident form was completed for this incident.		್

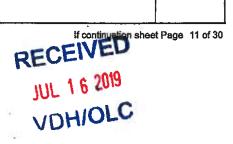
that residents receive treatment and care in

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MUL A. BUILD		CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495320	B. WING			06/	20/2019	
NAME OF P	ROVIDER OR SUPPLIER			Ş	TREET ADDRESS, CITY, STATE, ZIP CODE			
	THE SUBSTITUTE			1:	225 CLINTWOOD MAIN STREET, ROUTE 607 P	O BOX 909		
HERITAGE	HALL CLINTWOOD			C	LINTWOOD, VA 24228			
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F 684	Continued From page	9		684	Residents #89's attending physicians			
	accordance with profe		'	007	notified that the facility staff failed to			
.	-	essional standards of nensive person-centered			provide Restorative nursing services p			
	care plan, and the res		ŀ		physician order. A facility Incident & Accident form was completed for this			
1		is not met as evidenced			incident.			
.	by:	is not met as evidenced			more and	18		
İ	Based on clinical rec	ord review and staff			Identification of Deficient	9		
		mined the facility failed to			Practices/Corrective Action(s):			
		ered restorative services to			All other residents with physician ord			
	2 of 28 residents (Res				Restorative nursing services may have	3		
}	Z OI ZO TESIDENIS (NE	sidents #00 and 05).			potentially been affected. The DON,			
	Findings:				ADON and/or Unit Manager will con	luct		
i	rindings.				a 100% audit of all residents with physician ordered Restorative nursing	- 6		
	1 English staff failed t	to provide ohysician ordered			services to identify residents at risk.			
i		or Resident # 66. His clinical			Residents identified at risk will be	\$7		
		mpleted on 6/19/19 at 2:00			corrected at time of discovery and the	18		
	PM.	impleted off of 19/19 at 2.00			attending physician will be notified of			
	LIAI.		-		each negative finding and a facility	- 13	±. 9	
	Pacident #66 was ad	mitted to the facility on	•		Incident & Accident Form will be			
		s included cerebral vascular			completed for each negative finding.			
	accident, aphasia, an		İ		S-4			
	accident, apriasia, an	d Hemilpegia.			Systemic Change(s): The facility policy and procedures have	11	1.2	
	The latest MDS (minis	mum data aat\ datad	İ		been reviewed and no revisions are	/C		
		sident with unimpaired			warranted at this time. The nursing			
		required the assistance of	[assessment process as evidenced by the	ne		
	•	oplish all the ADLS (activities	×		24Hour Report and documentation in			
		set-up only to eat. The MDS			medical record /physician orders rema	iins		
		ive session during the last 7			the source document for the developm			
	day look-back period.				and monitoring of the provision of car		i i	
	day look back period.				which includes, obtaining, transcribin	g	:0	
	The latest CCP (com	prehensive care plan)			and administering physician ordered medications, treatments and nursing			
		on 5/20/19 addressed his		1.0	services. The DON and/or Regional n	urse		
	need for staff assistar				consultant will inservice all licensed	4.50	:	
		l "Restorative care as			nursing staff on the procedure for			
	ordered*.	Trocoldato dalo da			obtaining, transcribing, and completing	ıg		
	,				physician medication and treatment			
	The resident's latest r	physician's orders were			orders. To include following and			
ļ	signed and dated on		}		providing Restorative nursing service	s per		
ļ	=	care as ordered: AROM	[physician order.	18		
		; Transfers(Bed to chair				£ 1		
RM CMS-256	7(02-99) Previous Versions Obs		L	Fac	RECEIVE JUL 1620 VDHIO	rua on shee	t Page 10 of 30	
					DECEIVE			
					KEO	40		
	020				162	בונ		
	0.40				JOL ,			
					UNHIO	LU		
					VDI			





	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG		PLETED	
		495320	B, WING		06	/20/2019	
	ROVIDER OR SUPPLIER E HALL CLINTWOOD		·	STREET ADDRESS, CITY, STATE, ZIP 1225 CLINTWOOD MAIN STREET, CLINTWOOD, VA 24228	CODE	07 PO BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 684	assist); Dressing/Groday)." The restorative care was reviewed. Betwee restorative was only five dates (6/5, 6/7, 6/7). The surveyor's findin administrator and DC On 6/20/19 at 8:26 A surveyor that she agreeded some work, with a copy of the pla and ensure the residordered restorative of No additional informathe survey team exit. 2. For Resident #89 follow physician's ordered restorative nursing servestorative nursing servestorative nursing servestorative nursing servestorative nursing servestorative, dedisorder, hypothyroid The most recent quaset) with and ARD (a of 05/23/19 coded the long and short term of the survey recent quaset) with and ARD (a of 05/23/19 coded the long and short term of the survey recent quaset) with and ARD (a of 05/23/19 coded the long and short term of the survey recent quaset) with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with and short term of the survey recent quaset with a survey recent qu	on (200ft every day with one coming (Brush hair every flow record for June 2019 pen Jun 1st and June 19th documented as provided on 1/19/6/12 and 6/14/19). In the administrator told the reed the restorative program of the presented the surveyor and to restructure the program ents got their physician are as planned. In the facility staff failed to ders for performing ervices. In the facility on ted on 01/11/18. Diagnoses ed anemia, hypertension, expression, psychotic	F	Monitoring: The DON will be responsantaining compliance ADON and/or Unit Man weekly Restorative Nur audits to monitor for conegative findings and o corrected at time of disciplinary action will needed. Aggregate find audits will be reported to Assurance Committee of review, analysis, and refor change in facility potential and the properties. Completion Date: 08/0	e. The DON, mager will perform using flow sheets mpliance. Any/all rerrors will be covery and the taken as ings of these to the Quality uarterly for commendations dicy, procedure,		
	Resident #89's clinic	al record was reviewed on					



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495320	B. WING_			06/	20/2019
	ROVIDER OR SUPPLIER			1:	TREET ADDRESS, CITY, STATE, ZIP CODE 225 CLINTWOOD MAIN STREET, ROUTE 607 PO I LINTWOOD, VA 24228	BOX 909	
(X4) ID PREFIX . TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	06/19/19 and contain order summary for Ju "Restorative nursing of motion) to left ad ri	ed a signed physician's ine 2019, which read in part for:PROM (passive range	F€	684	:*		
	the month of June 20 06/19/19 and read in x 5 reps". The flow sh PROM on 06/05/19, 0 and 06/14/19. There to indicate the PROM The surveyor spoke v consultant) on 06/19/	part, "PROM R and L UE/LE neet was initialed for the 06/07/19, 06/10/19, 06/12/19 was no other documentation I was being completed. with the RNC (regional nurse 19 at approximately 1645. How sheets do not reflect.			## # #		
	orders was discussed team during a meetin approximately 1615. No further information Treatment/Srvcs Mer CFR(s): 483.40(b)(1) §483.40(b) Based on assessment of a resident who display mental disorder or psedifficulty, or who has post-traumatic stress	n was provided prior to exit. Intal/Psychoscial Concerns I the comprehensive dent, the facility must ensure anys or is diagnosed with sychosocial adjustment a history of trauma and/or	F	742	F742 Corrective Action(s): Resident #91 has been seen by psych services per the attending physician recommendation. Resident #91 has also been reassessed by their attending physician and the resident's comprehensive plan of care has been revised accordingly. A facility Incident Accident form has been completed for this incident	10	·

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

Event ID: TOJN11

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JUL 1 6 2019

VDH/OLC Facility ID: VA0109

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTR			(X3) DATE COME	SURVEY PLETED
21		495320	B, WING		06	/20/2019
	ROVIDER OR SUPPLIER E HALL CLINTWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 742	assessed problem or practicable mental ar This REQUIREMENT by: Based on staff interversew, the facility sta 28 Residents in the semental and psychoso 91. The findings included The facility staff failed consult psych service physician for Resident Resident # 91 was a originally admitted to readmission date of included but were nounspecified intellectude depression. The clinical record for on 6/19/19 at 9:41 ar (minimum data set) a assessment with an adate) of 5/23/19. Sec cognitive patterns. In staff documented that (brief interview for multiple status was severely in Resident # 91 had on not limited to, "Referinitiated by the physical part of the physical procession of the physical pro	to attain the highest and psychosocial well-being; is not met as evidenced riew, and clinical record aff failed to ensure that 1 of survey sample received vices to attain the highest ocial well-being, Resident # d to provide information that as as ordered by the nt # 91 was completed. 61-year-old-female who was the facility on 6/14/12, with a 10/22/13. Diagnoses t limited to, schizophrenia, al disabilities, anxiety, and resident # 91 was reviewed in. The most recent MDS assessment was a quarterly ARD (assessment reference atton C of the MDS assesses Section C0500, the facility at Resident # 91 had a BIMS ental status) score of 6 out of that Resident # 91's cognitive impaired.	F 74	Identification of Deficie Corrective Action(s): All other residents with r for psych services consul been affected The DON Managers will conduct I all residents for residents psych services recomment not been seen by psych. I identified at risk will be services to establish apprinterventions. An incider form will be completed form will be completed form will be completed form will be completed form will be completed form will be completed form will be completed form will be completed form will be completed form will be completed form the facility policy and p been reviewed and no che warranted at this time. The Managers and/or RCC whour report daily to insure sident's current medical psychological intervention obtained as ordered. All will be reported to admit immediate corrective ac Monitoring: The Director of Nursing maintaining compliance. ADON and/or Unit Man perform chart audits we with the Care Plan caler compliance. Detailed fin audits will be reported to Assurance Committee for analysis, and recommence change in facility policy and/or practice. Completion Date:08/0	recommendations Itation may have I, ADON or Unit 00% review of s who have had inded, but have Residents seen by psych ropriate treatment int & accident for each incident. For each incident For each inc	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			A. BUILDIN	TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
	1	495320	B. WING_			06/20/2019	
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP COE 1225 CLINTWOOD MAIN STREET, ROU CLINTWOOD, VA 24228			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD BE E APPROPRIATE	(XS) COMPLETION DATE	
SS=E	reviewed and revised documented a proble "Mood/behavior/psyc91 has a dx (diagnos anxiety/depression/shas a flat effect on he interactions. She is a confusion noted at tir she is noted to repeal aughter." Intervention limited to, "Meditele of the clinical record for locate any documents Resident # 91 had be On 6/19/19 at 5:30 pr was made aware of the Conformed the surveyobeen seen by psych swould ensure that Repsych services within No further information presented to the surve conference on 6/20/19 Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(s) \$483.45 Pharmacy Scrutter and providings and biologicals them under an agreer	d on 5/24/19. The facility staff em area for Resident # 91 as, chotropic drug use Resident # sis) of schizophrenia. Resident # 91 er face, which is altered with awake and alert with mes. Usually understands at phrases, then burst into ons included but were not care as ordered." am, the surveyor reviewed r Resident # 91 and did not tation that reflected that een seen by psych services. am, the administrative team the findings as stated above. am, the director of nursing or that Resident # 91 had not services, but the facility esident # 91 was seen by in the next couple of weeks. In regarding this issue was yey team prior to the exit 19. cedures/Pharmacist/Records of (1)-(3) services yide routine and emergency is to its residents, or obtain ment described in lity may permit unlicensed	F 7	755 Corrective Action(s): Resident 21's attending physic been notified that the facility fensure that the physician order Namzaric was available from for administration to Resident facility Incident and Accident been completed for this incide	failed to red pharmacy #21. A form has		
						ED	

JUL 1 6 2019
VDH/OLC

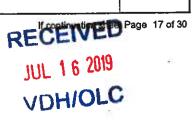
PRINTED: 07/02/2019 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED	
	495320	B. WING		06/20/2019
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD		12: CL	D BOX 909	
PREFIX (EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
a licensed nurse. §483.45(a) Procedupharmaceutical senthat assure the accidispensing, and adibiologicals) to meet §483.45(b) Service must employ or obtipharmacist who- §483.45(b)(1) Proviaspects of the provithe facility. §483.45(b)(2) Estal receipt and dispositisufficient detail to ereconciliation; and §483.45(b)(3) Deteorder and that an ais maintained and procedured that an ais maintained and procedured that the surfaceured that the surfaceured that are available for a residents in the surfaceured that and the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are available for a residents in the surfaceured that are a sur	ares. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. Consultation. The facility ain the services of a licensed des consultation on all ision of pharmacy services in the services of all controlled drugs in mable an accurate accurate accurate are in account of all controlled drugs periodically reconciled. Note in the services of a licensed drugs are in account of all controlled drugs are in account of all controlled drugs are in account of all controlled drugs are in account of all controlled drugs are in account of all controlled drugs are in account of all controlled drugs are in account of all controlled. The interest are in account of all controlled drugs are in account of all accoun	F 755	Resident 197's attending physician has been notified that the facility failed to ensure that the physician ordered Mar medication was available from pharm for administration. A facility Incident Accident form has been completed for this incident. Resident 94's attending physician has been notified that the facility failed to ensure that the physician ordered Mar was available from pharmacy for administration to Resident #94. A facil Incident and Accident form has been completed for this incident. Resident 16's attending physician has been notified that the facility failed to ensure that the physician ordered Cefd medication was available from pharma for administration to Resident #16. A facility Incident and Accident form has been completed for this incident. Resident 75's attending physician has been notified that the facility failed to ensure that the physician ordered Hydrocodone medication was available from pharmacy for administration to Resident #75. A facility Incident and Accident form has been completed for this incident.	rinol acy and r inol ility s

JUL 1 6 2019 VDH/OLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L DESTREICATION MUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495320	495320 8. WING			06/20/2019		
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO E CLINTWOOD, VA 24228			909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI * TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 755	pneumonia, dysphagedepression. On the assessment with ass 4/10/19, the resident short and long term impaired cognitive should be without signs of delir affecting care. During clinical record surveyor noted the Mecord (MAR) was veryor noted the Mecord for the explanation. The number of the medication nurse not been administered. The medication nurse not on the cart. The administrator are notified of the conce on 6/19/19. 2. For Resident #19 for administration. Resident #197 was 5/28/19 with diagnose obstructive pulmonal pneumonia, dysphagedepression, and characteristics.	gia, hypertension, and major quarterly minimum data set sessment reference date it was assessed as having memory deficits and severely kills and was assessed as itum, psychosis, or behaviors di review on 6/19/19, the Medication Administration was marked "N" for Namzaric igram capsule on 6/18/19, the entry did not provide an arsing progress notes for the essible the medication that the motified the medication had the ed. The stated the medication was and director of nursing were are during a summary meeting the progress of the stated the medication was and director of nursing were are during a summary meeting the progress of the facility on the ses including chronic and disease, heart failure, gia, hypertension, major onic pain. The resident did in data set assessment. The resident was not able to	F	755	Identification of Deficient Practice Corrective Action(s): All residents may have potentially be affected. A 100% review of all reside medication orders has been conducte the DON, QA nurseand/ or Unit managersto identify residents at risk. Residents found to be at risk due the medications being unavailable from pharmacy will be corrected at time of discovery and their attending physici will be notified. A facility Incident at Accident form has been completed for each. Systemic Changes: The Pharmacy Policy and Procedure been reviewed and no changes are warranted. All licensed nursing staff been inserviced on the Policy and Procedure for medication administration included medications that are unavailable or do not arrive at the fatimely from the pharmacy for administration. The inservice will in the steps the nurses should take shou medication not be delivered timely for the pharmacy. Monitoring: The DON is responsible for maintain compliance. The DON, ADON or Umanagerwill conductweekly audits or resident MAR's each week to confin availability of all ordered drugs. All negative findings will be corrected at time of discovery. Results of the rewill be reported to the Quality Assu Committee for review, analysis, and recommendations for change in facing policy, procedure, and/or practice. Completion Date:08/04/19	the of ians and or cility clude ald a from the lat the eviews arance d		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII			(X3) DATÉ SURVEY COMPLETED		
		495320	B, WING			06/	20/2019
	ROVIDER OR SUPPLIER E HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 PO BOX 909 CLINTWOOD, VA 24228			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 755	surveyor noted the Mecord (MAR) was we 2.5 milligram capsule two times per day on The MAR notes were administered- other of 4PM, 6/18 8AM, 6/18 other. Medication not avail administered- Other 6/14 at 8AM; 4-Other 6/14 at 8AM; 4-Other 6/14 8PM; 5- held 'proceed for the first of the capital administered of the capital administered of the capital administered. The nursing progres not address the failured address the failured in the medication. There we physician had been not been administered buring an interview of nursing reported that ordered from the physician sent, but the medication. The administrator are notified of the concessions.	I review on 6/19/19, the dedication Administration was marked "N" for Marinol ergive 2 capsules by mouth 6/12/19 through 6/18/19. The as follows: 1- Not on 6/13 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/13 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 6/15 8AM, 3- Not pending order clarification on r.special requirement not met pending provider clarification', 1, 6/17 8AM; 6- no M. Is notes for 6/13- 6/18/19 did are to administer the was no indication that the notified the medication had	F	755			
	on 6/19/19. 3. For Resident #94 administration.	l, Marinol was unavailable for					19
	5/31/19. Diagnoses weakness, dysphag	dmitted to the facility on included Alzheimer's, muscle ia, hypertension,and effux disorder. On the					•



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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING	(X3) DATE SURVEY COMPLETED
1	
495320 B. WING	06/20/2019
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE HALL CLINTWOOD MAIN STREET, ROUTE 60 CLINTWOOD, VA 24228)7 PO BOX 909
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPLICATION OF CROSS-REFERENCED TO THE APPLICATION O	OULD BE COMPLETION
F 755 Continued From page 17 admission minimum data set assessment with assessment reference date 67/19, the resident scored 8/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During clinical record review on 6/20/19, the surveyor noted the Medication Administration Record (MAR) was was marked "N" for Marinol 2.5milligram capsule give 2 capsules by mouth two times per day on 6/17/19 through 6/19/19. The MAR notes were as follows: 1- Not administered- other on 6/18 4PM and 6/19 8AM; 2- Not administered- other on 6/18 4PM and 6/19 8AM; 2- Not administered- other - 'pending arrival from pharmacy' on 6/19 4PM; 3- Not administered- Other pending order clarification on 6/18 at 8AM. The nursing progress notes for 6/13- 6/18/19 did not address the failure to administer the medication. There was no indication that the physician had been notified the medication had not been administered During an interview on 6/20/19, the director of nursing reported that the medication had been ordered from the pharmacy and the paper prescription sent, but the pharmacy had not sent the medication. The administrator and director of nursing were notified of the concern on 6/20/19. 4. For Resident #16 the facility staff failed to ensure the medication Cefdinir was available for administration. According to "Davis Drug Guide", Cefdinir is an antibiotic used to treat bacterial infections.	



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		D HUMAN SERVICES				• –	RM APPROVED NO. 0938-0391
		MEDICAID SERVICES	1				ATE SURVEY
TATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		DMPLETED
		495320	B. WING				06/20/2019
NAME OF PR	NAME OF PROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE		
				1	1225 CLINTWOOD MAIN STREET, ROUTE	607 PO BOX 90	9
HERITAGE	HALL CLINTWOOD			(CLINTWOOD, VA 24228		
	CI IMMADV ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORR	ECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE APDEFICIENCY)	PROPRIATE	COMPLETION DATE
F 755	Continued From pag	e 18	F	755	5		
		tted on 05/18/19. Diagnoses					*2
	included but not limit	ed to anemia, hypertension,	i				
	henian prostatic hyp	erplasia, diabetes mellitus,					
71	dementia, chronic ob	estructive pulmonary disease,			1		
	intellectual disability,				•		
	The most recent ann	ual MDS (minimum data set)					
	with an ARD (assess	sment reference date) of			·		
	03/27/19 assigned the	ne Resident a BIMS (brief					
		status) score of 6 out of 15 in					1 1
	section C, cognitive	patterns.					
	Pacident #16's clinic	al record was reviewed on					
		ed a signed physician's order					1
	summary for May 20)19, which read in part					
	"Cefdinir 250 mg/ 5	ml susp. Administer 6 ml vial			,		
	g-tube BID (twice da	aily)". This order had a start			Ì		
	date of 05/18/19. Re	esident #16's eMAR	1				
	(electronic medication	on administration record) for					
5	the month of May 20	019 was reviewed and	-				
	contained an entry,	which read in part "Cefdinir					
	250 mg/5 ml susp. /	Administer 6 ml vial g-tube					
	BID". This entry was	s initialed with "N" on 06/19/19			Ĭ		
		t 9 AM and 5 PM. The notes R for these dates was					
		ined notes, which read in part					
		Scheduled: 9:00 AM,					1
	5/10/19: Cefdinir 25	i0 mg/5 ml susp) Cefdinir 250	102				
		nister mscheduled for					
	05/19/19 9:00 AM v	vas not administered-other.					
(0)		arification", "9:13 AM 5/20/19					
7.15	(Scheduled: 9:00 A	M, 5/19/19; Cefdinir 250				55	
	mg/5 ml susp) Cefd	linir 250 mg/5 ml susp					
	Administer msche	eduled for 05/19/19 9:00 AM					
	was not administer	ed-other, pending provider					1
	clarification", and "4	4:07 PM 5/20/19 (Scheduled:					

9:00 AM, 5/19/19; Cefdinir 250 mg/5 ml susp) Cefdinir 250 mg/5 ml susp Administer m...scheduled for 05/19/19 9:00 AM was not

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OLIZA	S SOR MEDICARE	MEDICAID SERVICES				OMB N	0 0938-0391
CENTER	S FOR MEDICARE &	MEDICAID SERVICES		-		OMB NO. 0938-0391 (X3) DATE SURVEY	
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	1, ,	E SURVEY PLETED
		495320	B, WING			O6	5/20/2019
NAME OF PE	NAME OF PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
14741112 01 11				122	25 CLINTWOOD MAIN STREET, ROUTE 607	PO BOX 909	
HERITAGE	HERITAGE HALL CLINTWOOD			ı	INTWOOD, VA 24228		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIÈNCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 755	Continued From pag	a 10	E	755			
F 735	·		,	700			
·	administered-other. pclarification*.	bending provider					
	The curveyer speke	with the DON (director of	1		1.0		
	nursing) on 06/19/19						
0.5	regarding Resident	1					
	eMAR indicated the						
		so stated that it was probably		- 1			
	because the medical	tion had not arrived from the		- 1			
	pharmacy.						
		nedication not being available			100		1
	for administration wa	during a meeting on 06/19/19					
	at approximately 16						
	No further information	on was provided prior to exit.					
	5. For Resident #75	the facility staff failed to	.				
	ensure the medication						
	available for adminis	*					
	Pasident #75 was a	dmitted to the facility on					
	I .	litted on 03/01/19. Diagnoses		Ì			
		ted to anemia, hypertension,					
		depression, chronic					3
		ry disease, and benign		1			
	prostatic hyperplasia	а.					
	The most recent our	arterly MDS (minimum data					
		ssessment reference date) of	13	-			
		he Resident a BIMS (brief					
	interview for mental	status) score of 12 out of 15					
	in section C, cogniti	ve patterns.					
	Resident #75's clinic	cal record was reviewed on	8.3				
	1	ed a signed physician's order					
		onth of May 2019, which read					

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

in part "Hydrocodone-acetamin 10-325 mg 1

Event ID: TOJN11

Facility ID: VA0109

REOF TWO Seet Page 20 of 30



(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

PRINTED: 07/02/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES WIND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495320	B. WING			6/20/2019
	ROVIDER OR SUPPLIER E HALL CLINTWOOD		12	TREET ADDRESS, CITY, STATE, ZIP CO 125 CLINTWOOD MAIN STREET, RO LINTWOOD, VA 24228	ODE	
(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 ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 755	#75's eMAR (electron record) for the month and contained an enti "Hydrocodone-acetan" (by mouth) three time initialed with "N" on 0 notes section of the e which read in part "10 (Scheduled: 10:00 Pl Hydrocodone-acetam	hree times a day". Resident ic medication administration of May 2019 was reviewed y, which read in part nin 10-325 mg 1 tablet pos a day". This entry was 5/24/19 at 10:00 PM. The MAR contained a note, :47 PM, 5/24/19 y, 5/24/19; in 10-325 mg 1 05/24/2019 10:00 PM was	F 755		, *4 B	
F 758 SS=E	nursing) on 06/19/19 a regarding Resident #1 eMAR indicated the madministered. She als because the medication pharmacy. The concern of the medication was administrative team do at approximately 1615. No further information Free from Unnec Psyc CFR(s): 483.45(c)(3)(c) §483.45(e) Psychotrog §483.45(c)(3) A psychaffects brain activities	6. DON stated that "N" on nedication was not to stated that it was probably on had not arrived from the edication not being available discussed with the uring a meeting on 06/19/19 was provided prior to exit. Schotropic Meds/PRN Use (1)-(5) pic Drugs. otropic drug is any drug that associated with mental or. These drugs include,	F 758			
	land majora you so		1 _ [

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

Event ID: TOJN11

Facility ID: VA0109

RECENTATION neet Page 21 of 30



CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB N	<u>0.0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		STRUCTION	(X3) DATE SURVEY COMPLETED		
		495320	B. WING	-		06	/20/2019
NAME OF PR	OVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, ZIP CODE		I .
HERITAGE	HALL CLINTWOOD		<u> </u>		LINTWOOD MAIN STREET, ROUTE 607 WOOD, VA 24228	PO BOX 909	V
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	- ID PREFII TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 758	resident, the facility in §483.45(e)(1) Reside psychotropic drugs a unless the medication specific condition as in the clinical record; §483.45(e)(2) Reside drugs receive gradual behavioral interventic contraindicated, in an drugs; §483.45(e)(3) Reside psychotropic drugs punless that medication diagnosed specific or in the clinical record; §483.45(e)(4) PRN or are limited to 14 days §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he or rationale in the reside indicate the duration §483.45(e)(5) PRN or \$483.45(e)(5) e)(6) PRN or \$483.45(e)(6)(e)(6) PRN or \$483.45(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(e)(ensive assessment of a nust ensure that— ents who have not used re not given these drugs in is necessary to treat a diagnosed and documented ents who use psychotropic al dose reductions, and ons, unless clinically in effort to discontinue these ents do not receive entraunt to a PRN order on is necessary to treat a condition that is documented and enter for psychotropic drugs is. Except as provided in attending physician or her believes that it is RN order to be extended or she should document their ent's medical record and	F	758	F 758 Corrective Action(s): Resident 45's attending physician notified that facility staff failed to resident #45for side effects and effectiveness of the physician orded Lexapro. Resident 45's physician reviewed resident 45's medication and no adjustments to the medicat regime are required. A facility Incaccident form was completed for incident. Resident 56's attending physician notified that facility staff failed to resident #56 for side effects and effectiveness of the physician orded Trazadone. Resident 56's medication and no adjustments to the medicat regime are required. A facility Incaccident form was completed for incident. Resident 65's attending physician notified that facility staff failed to resident #65 for side effects and effectiveness of the physician order frozac. Resident 65's physician notified that facility staff failed to resident #65 for side effects and effectiveness of the physician order order regime are required. A facility Incaccident form was completed for incident.	monitor ered has regime tion bident & this was monitor ered an has a regime tion bident & this was monitor ered an has a regime tion bident & this was monitor ered as a regime tion bident & this	

CENTER	S FOR MEDICARE &	MEDICAID SERVICES	72			OWR M	<i>).</i> 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495320	B. WING		itos m	06	/20/2019
NAME OF PI	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				1:	225 CLINTWOOD MAIN STREET, ROUTE 607 PO	BOX 909	
HERITAGE	E HALL CLINTWOOD			C	LINTWOOD, VA 24228	=5:	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) .	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	the appropriateness of This REQUIREMENT by: Based on staff intervand facility document to ensure that 4 of 28 sample were free of unedications, Resider Resident #65, and Resident #65, and Resident #65, and Resident #45 for side effects and Resident #45 was at was admitted to the foreadmission date of 15 but were not limited to disorder, hypertension mellitus. The clinical record for reviewed on 6/18/19 MDS (minimum data quarterly assessment reference date) of 4/1 assesses cognitive pathe facility staff document a BIMS (brief intersore of 4 out of 15, v. Resident #45's cognimpaired.	er evaluates the resident for of that medication. is not met as evidenced liew, clinical record review, review the facility staff failed Residents in the survey unnecessary psychotropic at #45, Resident #56, esident #89. failed to monitor Resident # d effectiveness of Lexapro. In 89-year-old-female who acility on 6/9/15, with a 1/9/19. Diagnoses included to, anxiety, major depressive in, and type 2 diabetes In Resident # 45 was at 4:23 pm. The most recent set) assessment was a twith an ARD (assessment 16/19. Section C of the MDS atterns. In Section C0500, mented that Resident # 45 erview for mental status)	F	758	Resident 89's attending physician was notified that facility staff failed to moniversident #89 for behaviors related to the administration of the physician ordered Seroquel. Resident #89's physician has reviewed resident #89's medication regime and no adjustments to the medication regime are required. A facil Incident & Accident form was complete for this incident. Identification of Deficient Practice(s) and Corrective Action(s): All other residents receiving psychotro medications may have been potentially affected. The DON, ADON, and/or Pharmacy consultant will review the medication orders of all residents receiving psychotropic medication toidentify residents without appropriate psychotropic medication monitoring. Any/all negative findings be communicated to the attending physicians for corrective action. A Facility Incident & Accident form will completed for each negative finding.	ity ed pic t	
	reviewed and revised documented a proble	are for Resident # 45 was on 4/17/19. The facility staff on area for Resident # 45 as, sychosocial wellbeing &					



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495320	B. WING	B. WING			20/2019
	ROVIDER OR SUPPLIER HALL CLINTWOOD			12	TREET ADDRESS, CITY, STATE, ZIP CODE 125 CLINTWOOD MAIN STREET, ROUTE 607 PO LINTWOOD, VA 24228	BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 758	(diagnosis) of depres is alert & oriented, she enjoys bingo, Reside anxious. For this reviexhibited any behavioreduction) done this interventions include "Notify MD (medical depression of the physician on 1/9/On 6/19/19 at 1:41 pune 2019 medication Resident # 45. The standard monitored Resident # 45. The standard monitored Resident # 45 that has taff on 4/16/19. The documentation that the Resident # 45 for side associated with the unit on 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit on 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit on 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit on 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit on 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit of 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit of 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit of 6/19/19 at 5:30 puns made aware of the surveyor also resident # 45 for side associated with the unit of 6/19/19 at 5:30 puns made aware of the facility staff.	e: Resident # 45 has a dx sion/anxiety, Resident # 45 he smiles and says she nt # 45 does say she gets ew Resident # 45 has not lors. GDR (gradual dose review, please see chart." do but were not limited to, doctor) of any changes." The president for the faction of the faction of the findings as stated above. The president for the exit included to the faction of the faction of the findings as stated above. The president for the exit included to the faction of the f	F	758	Systemic Change(s): The facility Policy and Procedure has been reviewed. No revisions are warranted at this time. All nursing staff will be inserviced by the DON and/or regional nurse consultant and issued a copy of the facility policy and procedure for proper administration and monitoring for behaviors, side effects and effectiveness of psychotropic medications. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will complete weekly physician orders and MAR audits on all residents receiving psychotropic medications to monitor compliance. All negative findings will be corrected immediately and appropriate disciplinary action will be taken as necessary. Aggregate findings of these audits will be provided to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date:08/04/19	e g	
	of for side effects an	d effectiveness associated	1		1		1



DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING ...

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495320	B. WING		0	6/20/2019	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE CLINTWOOD, VA 24228				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 758	Continued From page	e 24	F 75	i8			
· (0	with the use of Trazo	done.		**			
	originally admitted to a readmission date o	t limited to, anxiety, major					
	MDS (minimum data quarterly assessment reference date) of 5/5 assesses cognitive puthe facility staff docur	at 4:37 pm. The most recent set) assessment was a t with an ARD (assessment 9/19. Section C of the MDS atterns. In Section C0500, mented that Resident # 56 erview for mental status) , which indicated that		<i>t</i> p			
	reviewed and revised documented a proble "Mood/behavior/psyc # 56 has a dx (diagnoschizophrenia, anxiet depression. Resident such as yelling from onursing staff instead exhibits with persistal example) male vendo gravitates to them. Si staff not to put things when roommates usin Interventions included "Notify MD (medical oparty) of any changes						
		ders that included but were done 150.mg (milligram)		£1			

PRINTED: 07/02/2019 **FORM APPROVED**

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	0.0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495320	B. WING			06/	20/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGI	E HALL CLINTWOOD				25 CLINTWOOD MAIN STREET, ROUTE 607 PO INTWOOD, VA 24228	BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 758	Continued From page	e 25	F	758			
. *		QHS (every night at initiated by the physician on					1.0
200	June 2019 medication Resident # 56. The standard monitored Resident effectiveness association of the survey facility "Psychotropic"	m, the surveyor reviewed the n administration record for urveyor did not locate any effected that the facility staff ent # 56 for side effects and ated with the use of eyor also reviewed the Medication Quarterly Eval* i6 that had been completed					
	locate any document	V19. The surveyor did not ation that the facility staff 56 for side effects and ated with the use of					
		m, the administrative team he findings as stated above.					
		n regarding this issue was yey team prior to the exit 19.					
		failed to monitor Resident # d effectiveness associated ac.	# #5				
	was admitted to the f	n 86-year-old-female who facility on 2/28/19. Diagnoses t limited to, hypertension, 2 diabetes mellitus.				ų.	
	MDS (minimum data quarterty assessment	at 4:13 pm. The most recent set) assessment was a t with an ARD (assessment			PECEI	/ED	
ORM CMS-256	37(02-99) Previous Versions Obs	solete Event ID:TOJ	N11	Faci	lity ID: VA0109	ation shoe	t Page 26 of 30

JUL 1 6 2019 VDH/OLC

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CENTER	S FUR MEDICARE &	MEDICAID SERVICES	LESS TO THE		Y-1-20-28 T - 2000 CONTO - 2000	OMP NO	. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495320	B. WING			06/	20/2019
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE	E HALL CLINTWOOD			l	25 CLINTWOOD MAIN STREET, ROUTE 607 PC LINTWOOD, VA 24228	BOX 909	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG)	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE ·	(X5) COMPLETION DATE
F 758	assesses cognitive per the facility staff docur cognitive status was a status was a status was a staff on 5/7/19. The status was a staff on 5/7/19. The status was a status wa	atterns. In Section C 1000, mented that Resident # 65's moderately impaired. are for Resident # 65 was fon 5/9/19. The facility staff em area for Resident # 65 as, shotropic drug use: Ing Resident # 65 has a dx thia, depression and mild. Resident # 65 denies exever sometimes has looks ommunicate with staff. Ind is cooperative." Indis cooperative. Indis coo	F	758			
	On 6/10/10 at 5:30 n	m the administrative team				VED	1



		THE CONTROL OF				VIVID IV	U. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			E SURVEY IPLETED
		495320	B. WING		·	06	5/20/2019
NAME OF P	ROVIDER OR SUPPLIER		• •	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	20/2013
HERITAG	E HALL CLINTWOOD			1	225 CLINTWOOD MAIN STREET, ROUTE 607 P CLINTWOOD, VA 24228	O BOX 909	a);
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From page	27		750			
in a	· -	ne findings as stated above.		758			
	presented to the survice conference on 6/20/11 4. For Resident #89 the behaviors related to the psychotropic medication. Resident #89 was add 07/14/17 and readmit included but not limited dementia, anxiety, dedisorder, hypothyroidion. The most recent quarted with and ARD (as of 05/23/19 coded the long and short term medical forms.)	ne facility failed to monitor ne administration of the ion Seroquel. mitted to the facility on ted on 01/11/18. Diagnoses ad anemia, hypertension, pression, psychotic sm and dysphagia. terly MDS (minimum data sessment reference date) Resident as having both nemory problems with	**************************************				€
	decision making. Resident #89's clinica 06/19/19. It contained summary for June 20' "Seroque! (quetiapine (by mouth) qd (every delectronic medication June 2019 was review which read in part "Setablet take 1 pill po (by The eMAR indicated the medication as prescrit Resident #89's clinica "Psychotropic Medication"	25 mg tablet take 1 pill po day)". Resident #89's eMAR administration record) for yed and contained an entry, roquel (quetiapine) 25 mg y mouth) qd (every day)". he Resident is receiving the ped. record contained iion Quarterly Evaluation" 12/05/18 and 05/22/19.					

PRINTED: 07/02/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) [(X3) DATE SURVEY COMPLETED	
		495320	8. WING_			06/00/0040	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL CLINTWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 1225 CLINTWOOD MAIN STREET, ROUTE 607 CLINTWOOD, VA 24228	PO BOX 9	06/20/2019 BOX 909	
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	E (X5) COMPLETION THE DATE	
F 761 SS=D	episode/week section form dated 05/22/19. The concern of the income Medication Evaluation the administrative teal 06/19/19 at approximation and the concern of the concern	dication section and the was incomplete on the complete Psychotropic forms was discussed with m during meeting on ately 1615. was provided prior to exit.	F 76	363 () ()	X	\$Z (A)	
	Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the eapplicable. §483.45(h) Storage of §483.45(h)(1) In accor Federal laws, the facili biologicals in locked cotemperature controls, apersonnel to have acces §483.45(h)(2) The facil locked, permanently at storage of controlled dithe Comprehensive Drugotton Act of 1976 and abuse, except when the package drug distributi	and cautionary xpiration date when Drugs and Biologicals dance with State and ty must store all drugs and compartments under proper and permit only authorized		the Medication room was removed an destroyed. A Facility Incident & Acci form has been completed for this incident have loose pills in two of the medicati drawers has been reviewed and all loo medications have been removed and disposed of. A Facility Incident & Accident form was completed for this incident. Identification of Deficient Practices Corrective Action(s): All unit medication rooms, medication refrigerators and medication carts used the storage medications may have bee potentially affected. The DON, ADON and/or Unit Manager will conduct a 16 review of the medication room, medication carts, and medication refrigerators to identify any expired on loose medications. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for incident identified.	d dent ent. on se		

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

Event ID: TOJN11

Facility ID: VA0109

If continuation sheet Page 29 of 30



PRINTED: 07/02/2019 FORM APPROVED

MAD PLAN OF CORRECTION A05320 STREET ADDRESS, CITY, STAYE, ZIF CODE	STATEMENT	OF DEFICIENCIES	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2)		_		OMB N	O. 0938-0391		
STREET ADDRESS, CITY, STATE, ZIP CODE	AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER.							
HERITAGE HALL CLINTWOOD 231 ID PREFIX SUMMARY STATEMENT OF DEPICIENCIES (EACH DEPICIENCY MAYS THE PRECEDED BY PAUL PRES) PROVIDER'S PLAN OF CORRECTION BOOLD BY PAUL PRESULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG			495320	B. WING		11277 ——————————————————————————————————				
F 761 Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to store drugs in accordance with accepted professional principles and to discard expired medications in one medication room and on one medication cart. On 6/19/19 at 1:40 PM, during medication storage room examination, in the right side medication storage refrigerator, the surveyor found a vial of lorazepam 20 miligram/10 milititer labeled for un-sampled Resident #37 which had expired 9/2018. Record review revealed the resident did not have a current order for lorazepam by injection. Inspection of the left side back hall medication cart revealed more than 10 loose pills in each of two of the medication storage drawers. The medication nurse disposed of the medications. The administrator and director of nursing were notified of the concern during a summary meeting on 6/19/19. F 761 Systemic Change(s): Systemic Change(s): Systemic Change(s): Systemic Change(s): F 761 Systemic Change(s): Facility policy and procedure for toring medic	HERITAG (X4) ID	E HALL CLINTWOOD SUMMARY STI (EACH DEFICIENCE	Y MUST BE PRECEDED BY FULL		12 Ci	25 CLINTWOOD MAIN STREET, ROUTE 607 PO LINTWOOD, VA 24228 PROVIDER'S PLAN OF CORRECTION	BOX 909			
This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, facility staff failed to store drugs in accordance with accepted professional principles and to discard expired medications in one medication room and on one medication cart. On 6/19/19 at 1:40 PM, during medication storage room examination, in the right side medication storage refrigerator, the surveyor found a vial of lorazepam 20 milligram/10 milliliter labeled for un-sampled Resident #37 which had expired 9/2018. Record review revealed the resident did not have a current order for lorazepam by injection. Inspection of the left side back hall medication cart revealed more than 10 loose pills in each of two of the medication storage drawers. The medication nurse disposed of the medications. The administrator and director of nursing were notified of the concern during a summary meeting on 6/19/19. Monitoring: The DON is responsible for maintaining compliance. All discrepancies found in these audits will be corrected at the time of discovery and discibilinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	J.		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	F	COMPLETION		
		This REQUIREMENT by: Based on observation staff failed to store druaccepted professional expired medications in on one medication car On 6/19/19 at 1:40 PM storage room examina medication storage refound a vial of lorazepa labeled for un-sampled expired 9/2018. Recorresident did not have a lorazepam by injection. Inspection of the left siccart revealed more than two of the medication smedication nurse dispontified of the concern and onotified of the concern and contified of the content and content	is not met as evidenced in and staff interview, facility logs in accordance with principles and to discard in one medication room and it. If, during medication ition, in the right side irrigerator, the surveyor itam 20 milligram/10 milliliter if Resident #37 which had ird review revealed the in current order for it de back hall medication in 10 loose pills in each of itorage drawers. The issed of the medications.	F7		Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly review of all Medication rooms, medication refrigerators and medication carts for medications to include injectables and unrefrigerated medications and biologicals that may be expired or opened with no date or laying loose in in the medication carts. In addition, The Pharmacy consultant will check each medication room and each medication cart for improper storage of medications during scheduled visits Monitoring: The DON is responsible for maintaining compliance. The DON and/or unit manager will perform weekly Medication room and Medication cartaudits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.				

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

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