DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/24/2019
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495152	A. BUILDING _____ B. WING _____	C 09/12/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	282 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/10/19 through 9/12/19. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 09/10//19 through 09/12/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 141 at the time of the survey. The survey sample consisted of 28 current Resident reviews and 2 closed record reviews.	F 000		
F 684 SS=D	Quality of Care CFR(s) 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure that a resident received treatment and care by following physician orders for 1 of 30 Residents,	F 684	**F684** **Corrective Action(s):** Residents #98's attending physician was notified that the facility failed to administer physician ordered Tricor as ordered by the physician. LPN #3 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Medication Error form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving medications may have been potentially affected. The DON, ADON, and/or Unit Managers will conduct a 100% audit of all residents	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawna Hurt per DNHA | TITLE: Administrator | (X6) DATE: 10-1-19

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

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F 684	Continued From page 1 Resident #98. The findings included: The facility staff failed to administer the Resident's tricor. The Resident had a physicians order for this medication to be administered daily. A review of the Resident's face sheet revealed that this Resident had been admitted to the facility on 06/14/19. The diagnoses on this face sheet included, but were not limited to, chronic kidney disease, malignant neoplasm of bladder, type 2 diabetes, hyperlipidemia, and chronic atrial fibrillation. Section C (cognitive patterns) of the Residents admission MDS (Minimum Data Set) assessment with an ARD (Assessment Reference Date) of 06/21/19 included a BIMS (Brief Interview for Mental Status) summary score of 15 out of a possible 15 points. On 09/11/19 at 8:27 a.m., the surveyor observed LPN (licensed practical nurse) #3 prepare and administer Resident #98's morning medications. After the medication administration, the surveyor reviewed the Residents clinical record. The clinical record included "Physicians Orders" for the month of September 2019. Page 2 of 6 of these orders included the order "TRICOR 145 MG TABLET 1 tab p.o. (by mouth) QD (everyday) Dx (diagnosis) hyperlipidemia." The surveyor did not observe LPN #3 prepare and/or administer this medication to Resident #98. On 09/11/19 at 9:27 a.m., LPN #3 and the surveyor checked the medication cart and this	F 684	MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes following and administering medications per physician orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering medications per physician order. **Monitoring:** The DON will be responsible for maintaining compliance. The DON,ADON and/or Unit Managers will audit resident MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 10-25-19**	

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F 684	Continued From page 2 medication was available for administration. LPN #3 verbalized to the surveyor that she did not usually work this station (unit) and stated she could not confirm that she gave this medication. On 09/11/19 at 3:34 p.m., during a meeting with the survey team the administrator and nurse consultant were made aware that LPN #3 did not administer the Residents tricor per the physician order. No further information regarding this issue was provided to the survey team prior to the exit conference on 09/12/19.	F 684		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 761	**F761** **Corrective Action(s):** The unlabeled Tresiba flex touch pen in the medication cart on unit #1 was removed and discarded and an new Tresiba flex touch pen with the appropriate labeling information was obtained from the pharmacy. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All unit medication rooms, medication refrigerators and medication carts used for the storage Insulin flex pens may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of the medication rooms, medication carts, and medication refrigerators to identify any inappropriate or mislabeled labeled insulin pens and/or medication. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified.	

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F 761	Continued From page 3 abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to ensure a medication was labeled per their policy and procedure on 1 of 4 station's, station #1. The findings included: The medication administration cart on station #1 included a Tresiba flex touch pen (insulin) that was not labeled with a Residents name or any identifying information. On 09/11/19 at 8:27 a.m., during a medication pass and pour observation on station #1 LPN #3 removed a Tresiba flex touch pen from the medication cart. This Tresiba flex touch pen was not labeled with any identifying information to indicate whom this medication was for. When asked how you would know who this medication was for LPN #3 verbalized to the surveyor that since it was not labeled she did not know for sure who it was for and stated this was not the medication cart she usually worked. The facility policy/procedure titled, "Labeling of Medication Containers" read in part, "...Labels for individual drug containers shall include all necessary information, such as...The Resident's name..." On 09/11/19 at 3:34 p.m., during a meeting with	F 761	**Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nursing staff will 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 injectable medications and biologicals that may not be labeled with the correct resident information or medication instructions. In addition, The Pharmacy consultant will check each medication room and each medication cart for improper labeling of medications during scheduled monthly visits. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or unit manager will perform weekly Medication room and Medication cart audits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery. 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. **Completion Date: 10-25-19**	

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F 761	Continued From page 4 the survey team the administrator and nurse consultant were made aware that the medication cart on station #1 included a Tresiba flex touch pen that was not labeled with any identifying information to include a Resident's name. On 09/12/19 at 10:30 a.m., during an interview with the unit manager on station #1. The unit manager stated he had discarded the unlabeled Tresiba. On 09/12/19 at 11:10 a.m., surveyor #2 checked the medication carts on station #1, station #4, and the middle cart. Surveyor #2 also checked the medication rooms on station #1 and #4 with no further issues identified. No further information regarding this issue was provided to the survey team prior to the exit conference on 09/12/19.	F 761		

State of Virginia

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F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 09/10//19 through 09/12/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 141 at the time of the survey. The survey sample consisted of *28 current Resident reviews and 2 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for Licensure of Nursing Facilities Nursing Services 12 VAC-5-371-220 (A,B, C)-cross reference to F684 Pharmacy Services 12 VAC-5-371-300-cross reference to F761	F 001		

RECEIVED
OCT 04 2019
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dawna Hiatt
TITLE: RN - Administrator
(X6) DATE:

PRINTED: 09/24/2019
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State of Virginia

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Davina Hiatt RN CNHA — TITLE: Administrator — (X6) DATE: 10-1-19