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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 01/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted 1/8/20 through 1/10/20. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 171 at the time of the survey. The survey sample consisted of 25 resident reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the	F 580	F580 Corrective Action(s) Resident #10's responsibility party has been notified of the resident to resident incident which occurred on 10/27/19. A Facility Incident & Accident form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All other residents may have potentially been affected. The DON and Unit Manager will conduct a 100% review of all resident records to identify residents who have not had resident to resident altercations reported to their responsible party in the past 90 days. An incident & accident form will be completed for all negative findings and will be corrected at time of discovery. Systemic Change(s): The facility policy and procedure have been reviewed and no changes are warranted at this time. Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the notification of physicians and responsible party regarding changes in resident condition and incidents involving a resident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 1/27/20

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 580	Continued From page 1 resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to notify a resident's responsible party of a resident-to-resident incident for one (1) of 25 sampled residents (Resident #10). The findings include: The facility staff failed to notify Resident #10's responsible party of the resident being involved in a resident-to-resident incident on 10/27/19. Resident #10's clinical record indicated the resident had diagnoses including, but not limited to: anemia, dysrhythmias, and non-Alzheimer's dementia. Resident #10's minimum data set	F 580	**Monitoring:** The DON is responsible for maintaining compliance. The DON will complete weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the QA committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: 2/14/20**	

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F 580	Continued From page 2 (MDS) assessment, with an assessment reference date (ARD) of 9/6/19, documented the resident as being scored a five (5) out of 15 for the Brief Interview for Mental Status (BIMS) score. Resident #10 was also assessed as exhibiting physical and verbal behavioral symptoms toward others. The following information was found in a facility policy/procedure titled "Abuse, Neglect and Exploitation Prevention and Reporting" (with a revised date of 11/2016): "Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline. When abuse, neglect or exploitation is suspected, the Licensed Nurse [sic] should: ... d. Notify the attending physician, [sic] resident's family/legal representative." Resident #10's care plan included the following "Problem/Need" (with an onset date of 9/12/19): "ACTIVITIES: Alert with very limited mental abilities due to Dementia. Periods of agitation and yells out." Resident #4's clinical documented included a note about a resident-to-resident incident between Resident #4 and Resident #10; this incident occurred on 10/27/19. (Resident #10 was not named in Resident #4's clinical record. The facility's investigation of the event identified that Resident #10 was involved.) This documentation reported that Resident #4 "hit" or "slapped" (Resident #10) on the left side of the head. Resident #10's clinical record failed to include documentation of this resident-to-resident incident. (The facility's investigation of this event included information related to medical provider notification and interventions implemented.) No evidence was found to indicate Resident #10's.	F 580		

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F 580	Continued From page 3 responsible party had been notified of this event. The failure of the facility staff to notify Resident #10's responsible party of the 10/27/19 resident-to-resident incident was discussed with the facility's administrative team on 1/9/20 at 4:35 p.m. and on 1/10/20 at 3:15 p.m. (The facility's administrative team included: the Administrator, the Corporate Nurse, the Director of Nursing, and the Assistant Director of Nursing.)	F 580		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State	F 609	F609 Corrective Action(s): A Facility Reported Incident has been completed on the incident which occurred between residents #4 and #10 on 10/27/19. Findings of the completed investigation have been reported also. A Facility Reported Incident has been completed on the incident which occurred between residents #13 and #25 on 7/3/19. Findings of the completed investigation have been reported also. Identification of Deficient Practices & Corrective Action(s): All other residents may have been affected. A 100% review of all resident records to identify residents in the last 90 days who have not had FRI's completed regarding reportable resident to resident incidents has been completed to identify residents at risk. An FRI has been completed for each of these incidents. Findings of the resulting investigations have also been reported.	

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F 609	Continued From page 4 Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to notify the state agency of resident-to-resident incidents for two (2) of 12 reviewed resident-to-resident incidents. (Residents involved were Resident #4, Resident #10, Resident #13, and Resident #25.) The findings include: 1. The facility staff failed to notify the state agency of a resident-to-resident incident that occurred between Resident #4 and Resident #10 on 10/27/19. Resident #10's clinical record indicated the resident had diagnoses including, but not limited to: anemia, dysrhythmias, and non-Alzheimer's dementia. Resident #10's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/6/19, documented the resident as being scored a five (5) out of 15 for the Brief Interview for Mental Status (BIMS) score. Resident #10 was also assessed as exhibiting physical and verbal behavioral symptoms toward others. The following information was found in a facility policy/procedure titled "Abuse, Neglect and Exploitation Prevention and Reporting" (with a revised date of 11/2016): "Response and Reporting of Abuse, Neglect and Exploitation - Anyone in the facility can report suspected abuse to the abuse agency hotline...When abuse,	F 609	**Systemic Change(s):** Policy and Procedure for reporting resident abuse & neglect has been reviewed. No changes are required. All administrative staff will be inserviced on the facility Abuse prevention and reporting policy and procedures regarding completion of FRI's and completion/reporting of investigations. The Administrator (designee in his/her absence) is responsible for completing internal investigations for all reported incidents of injuries of unknown origin, abuse, neglect, unusual occurrences, misappropriation of resident property and resident to resident altercations. The administrator (designee in his/her absence) will review all findings and complete the resulting FRI if indicated. **Monitoring:** The Administrator is responsible for maintaining compliance. All Facility Incident & Accidents forms will be reviewed daily by the Administrator to ensure any reportable items are investigated and reported as required. Confidential files of reported incidents and all follow-up documentation will be maintained in the Administrator's office. The Risk Management Committee will review I&A Reports to identifying and/or correcting negative patterns of completion weekly. All negative findings will be reported and investigated. Aggregate	

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F 609	Continued From page 5 neglect or exploitation is suspected, the Licensed Nurse [sic] should: ... f. Contact the State Agency and the local Ombudsman office to report the alleged abuse." Resident #4's clinical documented included a note about a resident-to-resident incident between Resident #4 and Resident #10; this incident occurred on 10/27/19. (Resident #10 was not named in Resident #4's clinical record. The facility's investigation of the event identified that Resident #10 was involved.) This documentation reported that Resident #4 "hit" or "slapped" (Resident #10) on the left side of the head. No evidence was found by or presented to the survey team to indicate the facility had reported this resident-to-resident incident to the state agency. The failure of the facility staff to report the resident-to-resident incident was discussed with the facility's administrative team on 1/9/20 at 4:35 p.m. and on 1/10/20 at 3:15 p.m. (The facility's administrative team included: the Administrator, the Corporate Nurse, the Director of Nursing, and the Assistant Director of Nursing.) 2. For Resident #13, the facility staff failed to report an incident with another resident, Resident #25. Resident #13's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease with Early Onset, Bipolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, Paroxysmal Atrial Fibrillation, and Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus. The quarterly MDS (minimum data set) with an	F 609	findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. Completion Date: 2/14/20	

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F 609	Continued From page 6 ARD (assessment reference date) of 8/15/19 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns. Resident #13 is coded as requiring limited assistance in bed mobility and transfers and requiring extensive assistance with personal hygiene. A review of Resident #13's medical record revealed a nursing note dated 7/03/19 2:23pm stating Resident #13 was going down the hallway and another resident was coming up the hallway and Resident #13 would not move. Resident #13 and the other resident had an argument and Resident #13 hit the other resident in the back with no injury noted. The residents were separated. The administrator stated the facility did not report the incident as Resident #13 stated they accidentally hit Resident #25. The administrator provided the surveyor with an internal investigation, including a documented interview with Resident #13 who stated they tried to move Resident #25's wheelchair so they could get by and hit Resident #25 on the back accidentally. On 1/09/20 at 4:38pm, the surveyor notified the administrator, director of nursing, assistant director of nursing and the corporate nurse of the 7/03/19 nursing note and that the resident incident was not reported to the state agency. No further information regarding this issue was presented to the survey team prior to the exit conference on 1/10/20.	F 609		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842		

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F 842 Continued From page 7

§483.20(f)(5) Resident-identifiable information.
(i) A facility may not release information that is resident-identifiable to the public.
(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.

§483.70(i) Medical records.
§483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-
(i) Complete;
(ii) Accurately documented;
(iii) Readily accessible; and
(iv) Systematically organized

§483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-
(i) To the individual, or their resident representative where permitted by applicable law;
(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted

F 842

F842
Corrective Action(s):
Resident #10's physician has been notified that the resident's clinical record did not accurately reflect the incident which occurred with Resident #15 on 11/2/19.
Resident #10's clinical record has been updated with a late entry regarding the incident.

Resident #10's physician has been notified that the resident's clinical record did not accurately reflect the incident which occurred with Resident #4 on 10/27/19.
Resident #10's clinical record has been updated with a late entry regarding the incident.

Resident #9's attending physician has been notified that from 4/30/19 to 5/6/19 the resident's clinical record did not accurately reflect the physician's medication orders.
Resident #9's clinical record has been reviewed to ensure that the physician's current plan of care is accurately documented.

Identification of Deficient Practices & Corrective Action(s):
All other residents may have potentially been affected. The DON and Unit Manager will conduct a 100% review of all resident records to identify residents in the past 90 days who have not had resident to resident incidents documented in their record. An incident & accident form will be completed for all negative findings and will be corrected at time of discovery.

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by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:
Based on interviews and review of documents, it was determined the facility staff failed to ensure complete and accurate clinical records for three (3) of 25 sampled residents (Resident #9, Resident #10, and Resident #25).

The findings included:

1. Facility staff members failed to insure information related to resident-to-resident incidents were documented in Resident #10's

F 842

A 100% review of all resident records will be conducted to ensure that the resident's current comprehensive plan of care is accurately reflected in the record.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on clinical documentation standards and maintaining complete and accurate clinical records.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice.

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F 842	Continued From page 9 clinical record. Resident #10's clinical record indicated the resident had diagnoses including, but not limited to: anemia, dysrhythmias, and non-Alzheimer's dementia. Resident #10's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 9/6/19, documented the resident as being scored a five (5) out of 15 for the Brief Interview for Mental Status (BIMS) score. Resident #10 was also assessed as exhibiting physical and verbal behavioral symptoms toward others. The following information was found in a facility policy/procedure titled "Charting and Documentation" (with a revised date of July 2017): - "Policy Statement ... All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care." - "Policy Interpretation and Implementation ... 2. The following information is to be documented in the resident medical record: a. Objective observations; b. Medications administered ... e. Events, incidents or accidents involving the resident ... 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate." While reviewing the clinical documentation of another resident at the facility (Resident #15) and facility documents, it was noted that a resident-to-resident incident occurred between	F 842		

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F 842	Continued From page 10 Resident #15 and Resident #10; this incident occurred on 11/2/19. (Resident #10 was not named in Resident #15's clinical record. The facility's investigation of the event identified that Resident #10 was involved.) Review of Resident #10's clinical documentation failed to reveal documentation of the occurrence of the 11/2/19 resident-to-resident incident. During an interviewed on 1/10/20, the facility's Administrator was asked about the missing documentation; the Administrator confirmed the 11/2/19 resident-to-resident incident was not documented in Resident #10's clinical record. While reviewing the clinical documentation of another resident at the facility (Resident #4), it was noted that a resident-to-resident incident occurred between Resident #4 and Resident #10; this incident occurred on 10/27/19. (Resident #10 was not named in Resident #4's clinical record. The facility's investigation of the event identified that Resident #10 was involved.) Resident #10's clinical record failed to include documentation of this resident-to-resident occurrence. (The facility's investigation of this event included information related to medical provider notification and interventions implemented.) The failure of the facility staff to document Resident #10's involvement in a resident-to-resident incidence in the resident clinical record was discussed with the facility's administrative team on 1/9/20 at 4:35 p.m. and on 1/10/20 at 3:15 p.m. (The facility's administrative team included: the Administrator, the Corporate Nurse, the Director of Nursing, and the Assistant Director of Nursing.) 2. The facility staff failed to ensure Resident #9's	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 01/10/2020

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F 842	Continued From page 11 clinical documentation correctly captured the resident's provider orders on the medication administration record (MAR). Resident #9's clinical record indicated the resident had diagnoses including, but not limited to: obstructive uropathy, pneumonia, depression, and lung disease. Resident #9's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 5/6/19, documented the resident as being scored 15 out of 15 for the Brief Interview for Mental Status (BIMS) score. Resident #9 was also documented as receiving pain medications. Resident #9's provider orders included an order for a Fentanyl patch to be applied every 72 hours. Resident #9's MAR included this order twice for 4/30/19 through 5/9/19. During an interview on 1/9/20 at 3:20 p.m., the facility's Director of Nursing and Corporate Nurse acknowledged the Fentanyl patch order was on the medication administration record (MAR) twice. The DON was asked about the process for changing the Fentanyl patches. The DON reported the old Fentanyl patch is removed at the time the new patch is applied. The DON stated explicit documentation of the removal of the old Fentanyl patch is not required. The facility staff's duplication of Resident #9's Fentanyl patch order on the resident's MARs was discussed with the facility's administrative team on 1/9/20 at 4:35 p.m. and on 1/10/20 at 3:15 p.m. (The facility's administrative team included: the Administrator, the Corporate Nurse, the Director of Nursing, and the Assistant Director of Nursing.) 2. For Resident #25, the facility staff failed to	F 842		

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

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F 842	Continued From page 12 document a physical assessment following an incident with another resident, Resident #13. Resident #25's diagnosis list indicated diagnoses, which included, but not limited to Schizophrenia, Bipolar Disorder - Severe with Psychotic Features, Dementia with Behavioral Disturbance, Unspecified Psychosis, Generalized Anxiety Disorder, Type 2 Diabetes, and Chronic Obstructive Pulmonary Disease. The admission MDS (minimum data set) with an ARD (assessment reference date) of 3/29/19 assigned the resident a BIMS (brief interview for mental status) score of 15 out 15 in section C, Cognitive Patterns. Resident #25 is code as requiring supervision only for bed mobility, transfers, and personal hygiene. An internal facility document provided to the surveyor revealed that on 7/03/19, another resident (Resident #13) was trying to pass Resident #25 in the hallway when Resident #25 kept sticking their tongue out at Resident #13. Resident #13 stated they tried to move Resident #25's wheelchair so they could get by and accidentally hit Resident #25 on the back. Resident #25's medical record does not include documentation related to the above. Resident #13's medical record contains a nursing note dated 7/03/19 2:23 pm stating in part, Resident #13 hit another resident in the back with no injury noted. On 1/09/20 at approximately 4:40pm, the surveyor notified the administrator, director of nursing, assistant director of nursing and the corporate nurse that Resident #25's medical	F 842		

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F 842	Continued From page 13 record did not include a physical assessment following being hit on the back by another resident. On 1/10/20 at 2:15pm, the administrator stated he did not have any additional information. No further information regarding this issue was presented to the survey team prior to the exit conference on 1/10/20.	F 842		

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