PRINTED: 01/21/2020 FORM APPROVED OMB NO. 000% 0000

CENTER:		MERRO Secondario			<u>OMB NO</u>	<u>. 00.7% (c. 55)</u>
t		(X1) FROUNDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION	(X3) DATE : COMPL	.ETED
		495135	B. WNG		01/2	; 10/2020
NAME OF PR	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP C	ODE	
			Ì	2045 VALLEY VIEW DRIVE		
HERITAGE	HAIL BIG STONE GA	P 		BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	S	FO	00		
	survey was conduct Corrections are requ CFR Part 483 Fede requirements. The conduction bed facility was 171 The survey sample reviews.	census in this 180 certified at the time of the survey. consisted of 25 resident		F580		
F 580 SS=D	CFR(s): 483.10(g)(' §483.10(g)(14) Not (i) A facility must im consult with the res consistent with his representative(s) w (A) An accident inv results in injury and physician intervent (B) A significant ch mental, or psychos deterioration in hea status in either life- clinical complicatio (C) A need to alter a need to discontir treatment due to a commence a new (D) A decision to tr resident from the f §483.15(c)(1)(ii). (ii) When making r (14)(i) of this secti- all pertinent inform is available and pr physician.	ification of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident then there is- olving the resident which I has the potential for requiring ion; ange in the resident's physical, ocial status (that is, a alth, mental, or psychosocial threatening conditions or	F5	Resident #10's respons been notified of the resincident which occurre Facility Incident & Accibeen completed for this Identification of Defice Corrective Action(All other residents may been affected. The DO Manager will conduct all resident records to who have not had resident form will be accident form will be negative findings and time of discovery. Systemic Change(s): The facility policy and been reviewed and no warranted at this time. Licensed staff will be DON and/or Regional the notification of phy responsible party regaresident condition and a resident.	ident to resident d on 10/27/19. A cident form has s incident. cient Practices s): y have potentially N and Unit a 100% review of identify residents dentify residents their responsible ys. An incident & completed for all will be corrected at I procedure have changes are inserviced by the nurse consultant on ysicians and arding changes in	
			! !	TITLE		(X6) DATE
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGNATU	UKE	11115		1 1

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.

Facility ID: VA0106

RECEINAMENT Sheet Page 1 of 14

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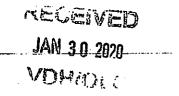
GENTER	S.FOR.MEDICARE &	MEDICAID SERVICES		and the second control of the second second second second	OMB NO. 0938-0
STATEMENT C	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPP IND PLAN OF CORRECTION IDENTIFICATION IN		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495135	B. WNG		01/10/2020
NAME OF PE	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE	
		_	2	2045 VALLEY VIEW DRIVE	
HERITAGE	E HALL BIG STONE GAI		E	BIG STONE GAP, VA 24219	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFILIED CONTRACTORY)	D BE COMPLET
F 580	Continued From pag	e 1	F 580		İ
	when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must	dent rights under Federal or ons as specified in paragraph n. record and periodically (mailing and email) and		Monitoring: The DON is responsible for maintain compliance. The DON will complete weekly chart audits coinciding with care plan calendar to monitor for compliance. Any/all negative findin will be corrected at time of discover Aggregate findings of these audits verported to the QA committee for reanalysis and recommendation for chin facility policy, procedure and/or practice.	e the gs y. vill be eview,
	that is a composite of §483.5) must disclosits physical configural locations that comprigant, and must spectroom changes between the second changes are second changes between the seco	IT is not met as evidenced s and the review of letermined the facility staff ident's responsible party of a incident for one (1) of 25 Resident #10).		Completion Date: 2/14/20	
	responsible party of a resident-to-reside Resident #10's clini resident had diagno	ed to notify Resident #10's if the resident being involved in nt incident on 10/27/19. cal record indicated the uses including, but not limited			
		thmias, and non-Alzheimer's	}		

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

Event ID: UJUD11

Facility ID: VA0106

If continuation sheet Page 2 of 14



PRINTED: 01/21/2020 FORM APPROVED OMB NO. 0938-0391-

CENTER	ENTERS FOR MEDICARE & MEDICARES PROJECT - 18-95	L'ONDERON	n Justines	STATE OF THE PARTY	OWID 140: 0530-512		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ISTRUCTION		E SURVEY IPLETED
		İ				İ	С
		495135	B. WNG			0-	1/10/2020
NAME OF P	ROVIDER OR SUPPLIER			STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
	- UALL BIG STONE CAL	a.		2045 \	VALLEY VIEW DRIVE		
HERITAGE	AGE HALL BIG STONE GAP			BIG S	STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
				500			
F 580	Continued From pag		F	580			1
	(MDS) assessment,						-
		o) of 9/6/19, documented the					
		ored a five (5) out of 15 for		!			
		or Mental Status (BIMS) I was also assessed as					
		nd verbal behavioral	i	- 1		•	
	symptoms toward of	hers					
	aymptoma toward of			ļ			1
	The following inform	ation was found in a facility		ļ			
	policy/procedure title	ed "Abuse, Neglect and					1
	Exploitation Prevent	ion and Reporting" (with a					
	revised date of 11/20	016): "Response and		-			Ī
	Reporting of Abuse,	Neglect and Exploitation -					
		y can report suspected abuse		-			İ
	to the abuse agency	hotline. When abuse, on is suspected, the Licensed		ŀ			
	neglect or exploitant	d. Notify the attending	ļ	l l			
	physician, [sic] resid			ŀ			
	representative." Re	sident #10's care plan					
	included the following	ng "Problem/Need" (with an					
	onset date of 9/12/1	9): "ACTIVITIES: Alert with		1			
	very limited mental	abilities due to Dementia.					
	Periods of agitation	and yells out."		1			ì
ļ].				
		al documented included a		1			•
		nt-to-resident incident	1	ı			
	between Resident	#4 and Resident #10; this n 10/27/19. (Resident #10	İ	1			
	was not named in 5	Resident #4's clinical record.					
		igation of the event identified		1			
	that Resident #10 v			-			
	documentation repo	orted that Resident #4 "hit" or					
	"slapped" (Residen	t #10) on the left side of the		j			
1	head. Resident #1	0's clinical record failed to	ļ	1			
1	include documentation of this resident-to-resident incident. (The facility's investigation of this event			İ			
				1			
	included informatio	n related to medical provider]	ŀ			
		erventions implemented.) No		1			
1	I avidence was found	d to indicate Resident #10's.	1 .		_		

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CENTER	SPORMET ESPEC	型EDE+できたISVICES みつこエ				SHENC	<u>LDScorrection</u>
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		E CONSTRUCTION		LETED
		495135	B. WING			01/	10/2020
NAME OF PR	ROVIDER OR SUPPLIER	455155	1 3	-	STREET ADDRESS, CITY, STATE, ZIP CODE	1 011	10/2020
HERITAGE	HALL BIG STONE GAF			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(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 F CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 580	Continued From page responsible party had	e 3 I been notified of this event.	F	580			
F 609 SS=D	#10's responsible paresident-to-resident in the facility's administ p.m. and on 1/10/20 administrative team in the Corporate Nurse the Assistant Director Reporting of Alleged CFR(s): 483.12(c)(1) §483.12(c) In response to the Assistant Director Reporting of Alleged CFR(s): 483.12(c)(1) Ensure involving abuse, negmistreatment, included source and misapproare reported immediate hours after the allegate that cause the allegate serious bodily injury, the events that cause abuse and do not rethe administrator of officials (including to adult protective server for jurisdiction in lon accordance with Staprocedures. §483.12(c)(4) Report investigations to the designated represervant.	ncident was discussed with rative team on 1/9/20 at 4:35 at 3:15 p.m. (The facility's included: the Administrator, the Director of Nursing, and or of Nursing.) Violations (4) Isse to allegations of abuse, or mistreatment, the facility ethat all alleged violations ethat all alleged violations injuries of unknown oppriation of resident property, ately, but not later than 2 ation is made, if the events ation involve abuse or result in or not later than 24 hours if ethe allegation do not involve sult in serious bodily injury, to the facility and to other the State Survey Agency and ices where state law provides geterm care facilities) in the law through established of the results of all administrator or his or her intative and to other officials in	F	609	F609 Corrective Action(s): A Facility Reported Incident has been completed on the incident which occur 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 occur between residents #13 and #25 on 7/3/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 reside records to identify residents in the last days who have not had FRI's complete regarding reportable resident to reside incidents has been completed to ident residents at risk. An FRI has been completed for each of these incidents. Findings of the resulting investigation have also been reported.	rred /19. on ent ed ent ify	
		ate law, including to the State					

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	H DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE	CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
1	NAME OF PROVIDER OR SUPPLIER		B. WING			01/	10/2020
NAME OF PR				Şī	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE	HALL BIG STONE GAF	•			045 VALLEY VIEW DRIVE NG STONE GAP, VA 24219		
(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)	LD BE	(X5) COMPLETI DATE
F 609	incident, and if the all appropriate corrective. This REQUIREMENT by: Based on interviews documents, it was defailed to notify the staresident-to-resident is reviewed resident-to-(Residents involved white the staresident involved white the staresident involved white the staresident involved white the staresident white the staresident white the start involved white the	n 5 working days of the leged violation is verified e action must be taken. F is not met as evidenced and the review of etermined the facility staff ate agency of incidents for two (2) of 12 resident incidents. were Resident #4, Resident and Resident #25.) willed to notify the state agency lent incident that occurred and Resident #10 on all record indicated the ses including, but not limited mains, and non-Alzheimer's #10's minimum data set with an assessment b) of 9/6/19, documented the ored a five (5) out of 15 for or Mental Status (BIMS) was also assessed as and verbal behavioral		609	Systemic Change(s): Policy and Procedure for reporting resident abuse & neglect has been reviewed. No changes are required administrative staff will be inservice the facility Abuse prevention and reporting policy and procedures regcompletion of FRI's and completion/reporting of investigation The Administrator (designee in his absence) is responsible for completinernal investigations for all reportincidents of injuries of unknown or abuse, neglect, unusual occurrence misappropriation of resident properesident to resident altercations. The administrator (designee in his/her absence) will review all findings at complete the resulting FRI if indicated the resulting FRI if indicated the Administrator is responsible for maintaining compliance. All Facili Incident & Accidents forms will be reviewed daily by the Administrate ensure any reportable items are investigated and reported as require Confidential files of reported incident and all follow-up documentation with maintained in the Administrator's The Risk Management Committee review I&A Reports to identifying correcting negative patterns of corweekly. All negative findings will reported and investigated. Aggregical reported and investigated. Aggregical reported and investigated.	ed on garding ons. Ther ing ted iggin, s, rty and e and ated. or ty c or to ed. ents vill be office. will and/or enpletion be	

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STATEMENT OF DEPRICISIONS (ACT) PROVIDERS UPPLIER (ACT) PROVIDERS (ACT) PROVIDERS (ACT) A BUILDING (ACT) PROVIDER OR SUPPLIER (ACT) DEMITICATION NUMBER: ABS135	CENTER	S FOR MEDICARE &	MEDICAID SERVICES		e obli		OMB N	IO. 0938-039
MANE OF PROMOBER OR SUPPLIER HERITAGE HALL BIG STONE GAP SUMMARY STATEMENT OF DERICIENCIES DATE OF DERICIENCIES SUBJECT OF DERICIENCIES SUBJECT OF DERICIENCIES SUBJECT OF DERICIENCIES SUBJECT OF DERICIENCIES SUBJECT OF DERICIENCIES SUBJECT OF DERICIENCIES SUBJECT OF DERICIENCY OF SEGULATORY OR LSC IDENTIFYING INFORMATION) F 609 Continued From page 5 neglect or exploitation is suspected, the Licensed Nurse [sci] should: "." 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 102/71/9. (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 for report the resident-to-resident incident to the state agency. The facility's administrative team included: the Administrator, the Corporate Nurse, the Director of Nursing, and the Assistant 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 incident, barry bases with Early Onset, Bipolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, Paroxysmal Atrial Fibriliation, and Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus.				1 ' '				
NAME OF PROMOTER OR SUPPLIER HERITAGE HALL BIG STONE GAP WATER MANARY STATEMENT OF DEPICIENCIES GENOME GAP, VA 24219 INFORMATION REPERLY TAG CONTINUED FROM INCOME SECULATORY OR LSC IDEMTHYNING INFORMATION) 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's clinical record. The facility's investigation of the event identified that Resident #4's clinical record. The facility's investigation of the event identified that Resident #4's us involved.) This documentation reported that Resident #4's reported to the survey team to indicate the facility had reported this resident-to-resident incident to the state agency. The facility's administrative team on 1/9/20 at 4.35 p.m. and on 1/7/20 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,			495135	B. WNG				_
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 1002/719. Resident #10 was not named in Resident #4' clinical record. The facility insetigation 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 sadministrative team on 19/20 at 4:35 p.m. and on 17/10/20 at 3:15 p.m. (The facility's administrative team on 19/20 at 4:35 p.m. and on 17/10/20 at 3:15 p.m. (The facility's administrative team included: the Administrator, the Corporate Nurse, the Director of Nursing). 2. For Resident #13, the facility staff failed to report an incident with another resident, Resident #25. Resident #13* diagnosis list indicated diagnoses, which incident, Ones the policy because of the purposes with Early Onset, Bipolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, Paroxysmal Atrial Fibrillation, and Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus.	HERITAGE (X4) ID	E HALL BIG STONE GAF	ATEMENT OF DEFICIENCIES		2045 BIG	5 VALLEY VIEW DRIVE STONE GAP, VA 24219 PROVIDER'S PLAN OF CORRE	CTION	
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 occumed on 10/27/19. (Resident #10 that Resident #4 sc linical record. The facility's investigation of the event identified that Resident #10 was involved.) This documentation reported that Resident #4's clinical record. The facility's investigation of the event identified that Resident #10 was involved.) This documentation reported that Resident #4's firit 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 to the state agency. The facilitys and instractive team on 19/20 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, Bjoolar Disorder, Major Depressive Disorder, Chronic Obstructive Pulmonary Disease, Paroxysmal Artial Fibrillation, and Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus.	TAG	REGULATORY OR Continued From page	LSC IDENTIFYING INFORMATION)	TAG	-	CROSS-REFERENCED TO THE APP		DATE
Depressive Disorder, Chronic Obstructive Pulmonary Disease, Paroxysmal Atrial Fibrillation, and Epilepsy, Unspecified, Not Intractable, Without Status Epilepticus.	, 503	neglect or exploitation Nurse [sic] should: and the local Ombud alleged abuse." Resident #4's clinical note about a resident between Resident #4 incident occurred on was not named in Re The facility's investig that Resident #10 wa documentation repor "slapped" (Resident: head. No evidence was the survey team to in reported this resident state agency. The failure of the fac resident-to-resident if the facility's administ p.m. and on 1/10/20 administrative team if the Corporate Nurse the Assistant Directo 2. For Resident #13 report an incident wii #25. Resident #13's diagr which included, but i	n is suspected, the Licensed . f. Contact the State Agency sman office to report the documented included a t-to-resident incident and Resident #10; this 10/27/19. (Resident #10 sident #4's clinical record. ation of the event identified as involved.) This ted that Resident #4 "hit" or #10) on the left side of the vas found by or presented to dicate the facility had t-to-resident incident to the iility staff to report the ncident was discussed with rative team on 1/9/20 at 4:35 at 3:15 p.m. (The facility's ncluded: the Administrator, the Director of Nursing, and or of Nursing.) the facility staff failed to the another resident, Resident hosis list indicated diagnoses, not limited to Alzheimer's			Assurance Committee for revie analysis, and recommendations changes in policy, procedure, as facility practice.	w, for	
		Disease with Early C Depressive Disorder Pulmonary Disease, and Epilepsy, Unspe Without Status Epile	Onset, Bipolar Disorder, Major , Chronic Obstructive Paroxysmal Atrial Fibrillation, crified, Not Intractable, pticus.					

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		MEDICAID SERVICES					RM APPROVED	
		MEDICALD SEGVICES ALLOW				OMB NO: 0988-0391:		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		NSTRUCTION		IPLETED	
		495135	B. WING			η.	C 1/10/2020	
NAME OF PR	ROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE		171072020	
		_		2045	VALLEY VIEW DRIVE			
HERITAGE	ERITAGE HALL BIG STONE GAP			BIG	STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE	
F 609	assigned the residen mental status) score Cognitive Patterns. requiring limited assi transfers and requiring personal hygiene. A review of Resident revealed a nursing nestating Resident #13 and another resident and Resident #13 with #13 and the other reresident #13 hit the	e 6 eference date) of 8/15/19 et a BIMS (brief interview for of 14 out of 15 in section C, Resident #13 is coded as istance in bed mobility and ang extensive assistance with #13's medical record to the dated 7/03/19 2:23pm is was going down the hallway to was coming up the hallway ould not move. Resident esident had an argument and other residents were	F	609				
	the incident as Residence accidentally hit Resident provided the survey investigation, including with Resident #13 who stated they wheelchair so they care #25 on the back accident.	dent #25. The administrator or with an internal ing a documented interview ratied to move Resident #25's could get by and hit Resident						
	administrator, direct director of nursing a 7/03/19 nursing note incident was not rep No further information presented to the sur conference on 1/10/	or of nursing, assistant and the corporate nurse of the e and that the resident corted to the state agency. On regarding this issue was evey team prior to the exit 1/20. Identifiable Information	F	F 842	• .			

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

Event ID: UJUD11

Facility ID: VA0106

If continuation sheet Page 7 of 14

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SELVER.	SEOR MEDICARE &	MEDICAID SERVICES				ОМВ ИО.	0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE (CONSTRUCTION	(X3) DATE S	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING		COMPLETED	
		į				С	
		495135	B. WNG			01/1	0/2020
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				204	45 VALLEY VIEW DRIVE		
HERITAG	E HALL BIG STONE GAP	S		Bie	G STONE GAP, VA 24219		
	CONTRADA CT	ATELIENT OF REPORTORS		I		· · ·	
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	,			i	F842		
F 842	Continued From page	e 7	F	842	Corrective Action(s): Resident #10's physician has been		
	§483.20(f)(5) Resider	nt-identifiable information,			notified that the resident's clinical reco	rd	
1		elease information that is		- 1	did not accurately reflect the incident		
	resident-identifiable to				which occurred with Resident #15 on		
		elease information that is	1		11/2/19.		
	resident-identifiable to				Resident #10's clinical record has been		
		intract under which the agent		İ	updated with a late entry regarding the		
	agrees not to use or o	disclose the information			incident.	1	
	except to the extent t	he facility itself is permitted			Desident #10's physician has been		
	to do so.				Resident #10's physician has been notified that the resident's clinical reco		
				- 1	did not accurately reflect the incident	10	
	§483.70(i) Medical re	cords.	1		which occurred with Resident #4 on		
	§483.70(i)(1) In accor	rdance with accepted			10/27/19.		
	1.	ds and practices, the facility			Resident #10's clinical record has been	.	
	must maintain medica	al records on each resident		l	updated with a late entry regarding the	.	
	that are-				incident.		
	(i) Complete;						
	(ii) Accurately docum			-	Resident #9's attending physician has	_	
	(iii) Readily accessible				been notified that from 4/30/19 to 5/6/1	19	
	(iv) Systematically or	ganized			the resident's clinical record did not		
	0.400 70/11/01 77				accurately reflect the physician's medication orders.	1	
		ility must keep confidential			Resident #9's clinical record has been		
	1	ned in the resident's records,	1		reviewed to ensure that the physician's		
		n or storage method of the		Į	current plan of care is accurately		
	records, except when				documented.		
	(i) To the individual, o			İ			
		permitted by applicable law;					
	(ii) Required by Law;	yment, or health care			Identification of Deficient Practices &	&	
		tted by and in compliance		1	Corrective Action(s):		
	with 45 CFR 164,506	· · · · · · · · · · · · · · · · · · ·	-		All other residents may have potentially	y	
		activities, reporting of abuse,			been affected. The DON and Unit Manager will conduct a 100% review o		
		violence, health oversight			all resident records to identify residents		
		l administrative proceedings,			the past 90 days who have not had	, m	
		poses, organ donation			resident to resident incidents document	ed	
		ourposes, or to coroners,			in their record. An incident & accident		
		uneral directors, and to avert		j	form will be completed for all negative		
1	· ·	ealth or safety as permitted		- 1	findings and will be corrected at time o		
1		J. Calety as politimos			discovery.		

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IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE S	
	A. BUILDI	ING_		COMPL	
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			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	ł	2	2045 VALLEY VIEW DRIVE		
	<u>-</u>	Ę	BIG STONE GAP, VA 24219		
JUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOULD B	BE	MOD
y must safeguard medical nst loss, destruction, or ecords must be retained quired by State law; or date of discharge when in State law; or after a resident reaches aw. cal record must containate to identify the resident; ent's assessments; plan of care and services areadmission screening sluations and ed by the State; and other licensed notes; and any and other diagnostic uired under §483.50. Is not met as evidenced and review of documents, it fility staff failed to ensure clinical records for three ents (Resident #9, dent #25).	F	842	A 100% review of all resident records will be conducted to ensure that the resident's current comprehensive plan care is accurately reflected in the reconstruction. 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 maintain compliance. The DON and/or design will audit medical records weekly coinciding with the care plan calenda monitor for compliance. Any/all negatifindings will be clarified and corrected the of discovery and disciplinary act will be taken as needed. The results of this audit will be provided to the Quarecommendations for change in facility.	of rd. ing cc r to tive d at tion f lity	
	A95135 EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) In the 45 CFR 164.512. If y must safeguard medical and loss, destruction, or decords must be retained and record must be retained and record must containate to identify the resident; ent's assessments; and other licensed and services areadmission screening aluations and red by the State; and other licensed notes; and and other diagnostic uired under §483.50. Is not met as evidenced and review of documents, it illity staff failed to ensure clinical records for three ents (Resident #9, ident #25).	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) Fifth 45 CFR 164.512. In must safeguard medical net loss, destruction, or decords must be retained and each of discharge when in State law; or safter a resident reaches aw. Cal record must containate in to identify the resident; ent's assessments; eplan of care and services areadmission screening aluations and ed by the State; and other licensed notes; and and other diagnostic uired under §483.50. Is not met as evidenced and review of documents, it illity staff failed to ensure clinical records for three ents (Resident #9, ident #25). In failed to insure esident-to-resident	EMENT OF DEFICIENCIES AUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION) F 842 TAG TAG F 842 TAG TAG F 842 TAG TAG F 842 TAG TAG F 842 TAG TAG F 8	STREET ADDRESS, CITY, STATE, 2IP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219 PREMIX TAG PREMIX TAG PREPIX TAG IT PROVIDER'S PLAN OF CORRECTION SHOULD E CROSS-REFERENCED TO THE APPROPRIED THAT PROPORTION SHOULD E CROSS-REFERENCED TO THE APPROPRIED THAT PROPORTION SHOULD E CROSS-REFERENCED TO THE APPROPRIED	STREET ADDRESS, CITY, STATE, 2IP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219 DEMENT OF DEFICIENCIES AUST DE PRECEDED BY FULL CIDENTIFYING INFORMATION) 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 policy, procedure, and/or practice. Completion Date: 2/14/20 In the state of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality policy, procedure, and/or practice. Completion Date: 2/14/20

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Event ID: UJUD11

Facility ID: VA0106

If continuation sheet Page 9 of 14



PRINTED: 01/21/2020 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER E HALL BIG STONE GAP			STREET ADDRESS, CITY, STATE, ZIP COI 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219	DE	
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F 842	clinical record. Resident #10's clinical resident had diagnosito: anemia, dysrhyth dementia. Resident (MDS) assessment, vereference date (ARD) resident as being scotthe Brief Interview for score. Resident #10 exhibiting physical ar symptoms toward othe The following information policy/procedure titled Documentation (with 2017): - "Policy Statement of the resident, progress to any changes in the refunctional or psychost documented in the remedical record should between the interdiscondition are "Policy Interpretation". "Policy Interpretation The following informations the resident medical observations; b. Med Events, incidents or a resident 3. Documercord will be objectively. Compleio While reviewing the canother resident at the facility documents, it	al record indicated the est including, but not limited mias, and non-Alzheimer's #10's minimum data set with an assessment of 9/6/19, documented the red a five (5) out of 15 for Mental Status (BIMS) was also assessed as id verbal behavioral iters. Ition was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction was found in a facility direction. All services provided to the ward the care plan goals, or esident's medical, physical, in a facilitate communication in the medical manual in the medical we (not opinionated or ite, and accurate."	F 8	342		
· -	resident-to-resident i	Holderit Occarred Detween		12-	- -	

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PRINTED: 01/21/2020 FORM APPROVED OMB NO. 0938-0391

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	X2) MULTIPLE CONSTRUCTION L BUILDING			(X3) DATE SURVEY COMPLETED		
							С		
·		495135	B. WNG	_		01/10/2020			
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
HERITAGI	E HALL BIG STONE GAR	.		ı	2045 VALLEY VIEW DRIVE				
11411111101	2.17.22.21.0 0.01.2 01.1				BIG STONE GAP, VA 24219				
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F 842	Resident #15 and Re occurred on 11/2/19. named in Resident # facility's investigation Resident #10 was in #10's clinical docume documentation of the resident-to-resident interviewed on 1/10/2 was asked about the Administrator confirm resident-to-resident in Resident #10's clin While reviewing the another resident at the was noted that a resoccurred between Rethis incident occurred was not named in Rethis incident #10 was clinical record failed this resident #10 was clinical record failed this resident-to-resident and interventions im The failure of the face Resident #10's involved in the facility's investigation information related the and interventions im The failure of the face Resident #10's involved in the face of the face Resident #10's involved in the face of the face Resident #10's involved in the face of the face Resident #10's involved in the face of the face Resident #10's involved in the face of the face	esident #10; this incident (Resident #10 was not 15's clinical record. The of the event identified that volved.) Review of Resident entation failed to reveal e occurrence of the 11/2/19 ncident. During an 20, the facility's Administrator emissing documentation; the ned the 11/2/19 ncident was not documented nical record. clinical documentation of the facility (Resident #4), it ident-to-resident incident esident #4 and Resident #10; d on 10/27/19. (Resident #10 esident #4's clinical record. pation of the event identified as involved.) Resident #10's to include documentation of lent occurrence. (The n of this event included o medical provider notification plemented.) cility staff to document vement in a incidence in the resident liscussed with the facility's on 1/9/20 at 4:35 p.m. and on (The facility's administrative Administrator, the Corporate of Nursing, and the Assistant	F	84					
	2. The facility staff i	failed to ensure Resident #9's	<u>i</u>		Complete Company		i		Constitution of the Consti

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495135	B. WNG		<u>.</u>	l o	C 1/10/2020	
	ROVIDER OR SUPPLIER E HALL BIG STONE GAI			204	EET ADDRESS, CITY, STATE, ZIP COI 5 VALLEY VIEW DRIVE 6 STONE GAP, VA 24219			
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F 842	clinical documentation resident's provider or administration record Resident #9's clinical resident had diagnostic obstructive uropa and lung disease. Reset (MDS) assessment reference date (ARC resident as being so Interview for Mental Resident #9 was als pain medications. Resident #9's provide for a Fentanyl patch Resident #9's MAR 4/30/19 through 5/9/1/9/20 at 3:20 p.m., Nursing and Corport Fentanyl patch order administration record was asked about the Fentanyl patch is repatch is applied. The documentation of the patch is not required. The facility staff's different per patch order discussed with the form 1/9/20 at 4:35 p. p.m. (The facility's the Administrator, the facility's the Administrator, the facility's the Administrator, the facility's the Administrator, the facility's the facility's the facility's the facility's the Administrator, the facility's the facility t	an correctly captured the refers on the medication of (MAR). I record indicated the ses including, but not limited athy, pneumonia, depression, esident #9's minimum data ent, with an assessment of 5/6/19, documented the bred 15 out of 15 for the Brief Status (BIMS) score. To documented as receiving of the applied every 72 hours. Included this order twice for 19. During an interview on the facility's Director of the Nurse acknowledged the reason the medication of (MAR) twice. The DON exprocess for changing the The DON reported the old moved at the time the new see DON stated explicit expression.	F	842				
7	2. For Resident #2	5, the facility staff failed to		ł			المتحافظ المادي	<u> </u>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3)	CM) DATE SURVEY COMPLETED C 01/10/2020	
		495135						
	ROVIDER OR SUPPLIER HALL BIG STONE O	SAP		204	EET ADDRESS, CITY, STATE, ZIP CO 5 VALLEY VIEW DRIVE 5 STONE GAP, VA 24219	DDE		
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F 842	incident with anoth Resident #25's dia which included, but Bipolar Disorder Features, Dement Unspecified Psychological Disorder, Type 2 Lobstructive Pulmo The admission MI ARD (assessment assigned the resident status) socionitive Pattern requiring supervistransfers, and per An internal facility surveyor revealed resident #25 in the kept sticking their Resident #13 status #25's wheelchair accidentally hit Resident #25's middoumentation resident #25's middoumentation resident #13's medical recidated 7/03/19 2:2 #13 hit another renoted. On 1/09/20 at apsurveyor notified	cal assessment following an ner resident, Resident #13. agnosis list indicated diagnoses, of not limited to Schizophrenia, Severe with Psychotic fia with Behavioral Disturbance, nosis, Generalized Anxiety Diabetes, and Chronic bonary Disease. DS (minimum data set) with an at reference date) of 3/29/19 dent a BIMS (brief interview for ore of 15 out 15 in section C, as. Resident #25 is code as as also nonly for bed mobility, as onal hygiene. In document provided to the at that on 7/03/19, another at #13) was trying to pass the hallway when Resident #25 are tongue out at Resident #13. Ted they tried to move Resident so they could get by and esident #25 on the back. Bedical record does not include elated to the above. Resident cord contains a nursing note 23 pm stating in part, Resident as ident in the back with no injury proximately 4:40pm, the the administrator, director of	F	842				
		t director of nursing and the hat Resident #25's medical			٠	-·· -· ·	- 5-10 <u>2:10</u>	! - ~

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Event ID: UJUD11

Facility ID: VA0106

If continuation sheet Page 13 of 14

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	ROVIDER/SUPPLIER/CLIA ENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
	495135				c	
	B. WINGSTREET ADDRESS, CITY, STATE, ZIP CODE			01/10/2020		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL BIG STONE GAP			20 Bi			
PREFIX (EACH DEFICIENCY MUST	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLÉTION DATE
F 842 Continued From page 13 record did not include a phy following being hit on the br resident. On 1/10/20 at 2:15pm, the he did not have any addition No further information rega presented to the survey tea conference on 1/10/20.	ack by another administrator stated enal information. arding this issue was	F	842			

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Event ID: UJUD11

Facility ID: VA0106

If continuation sheet Page 14 of 14

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