STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	C 05/12/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

(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 on 5/11/2021 through 5/12/2021. Corrections are required for compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000	**E029** **Corrective Action(s):** The Facility's Emergency Preparedness Plan has been revised and updated to ensure that the communication plan has been reviewed.	
E 029 SS=B	Development of Communication Plan CFR(s): 483.73(c) (c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC). This REQUIREMENT is not met as evidenced by: Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility staff failed to ensure the communication plan was reviewed on an annual basis. The findings were: During review of the communication plan portion of the Emergency Preparedness Plan, it was noted there was no documentation to indicate the communication plan was reviewed and updated as needed on an annual basis. At approximately 11.00 a.m. on 5/12/2021, the facility Administrator was interviewed regarding the communication plan. Asked if he had reviewed the communication plan, the Administrator said he had reviewed it, but had not signed off as having reviewed it. The finding was discussed during an end of	E 029	**Identification of Deficient Practice(s) & Corrective Action(s):** The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s);** Current facility policy & procedure for ensuring that the Emergency Preparedness Plan included policies and procedures that ensure the communication plan is reviewed annually. No changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. **Monitoring:** The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance. **Completion Date:**	06/15/2021

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

LNHA — Administrator — 05/24/2021

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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E 029	Continued From page 1 survey meeting that included the facility's administrative staff and the survey team.	E 029	**E031** **Corrective Action(s):** The Facility's Emergency Preparedness Plan has been revised and updated to ensure that the contact information portion of the communication plan is accurate. **Identification of Deficient Practice(s) & Corrective Action(s):** The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s);** Current facility policy & procedure for ensuring that the Emergency Preparedness Plan contains accurate contact information is reviewed annually has been reviewed and no changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. All staff will be inserviced by the administrator/designee on the Emergency Preparedness Plan. **Monitoring:** The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance. **Completion Date:**	06/15/2021
E 031 SS=B	Emergency Officials Contact Information CFR(s): 483.73(c)(2) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years (annually for LTC).] The communication plan must include all of the following: (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. *[For LTC Facilities at §483.73(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) The State Licensing and Certification Agency. (iii) The Office of the State Long-Term Care Ombudsman. (iv) Other sources of assistance. *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following: (i) Federal, State, tribal, regional, and local emergency preparedness staff. (ii) Other sources of assistance. (iii) The State Licensing and Certification Agency. (iv) The State Protection and Advocacy Agency. This REQUIREMENT is not met as evidenced by:	E 031		

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E 031	Continued From page 2 Based on review of the facility's Emergency Preparedness Plan and staff interview, the facility staff failed to ensure Emergency Officials contact information portion of the preparedness plan was reviewed on an annual basis. The findings were: During review of the Emergency Officials contact information portion of the Emergency Preparedness Plan, it was noted there was no documentation to indicate the contact information was reviewed and updated at least annually. Review of the contact information revealed at least one of the emergency contacts listed was no longer employed at the contact location. At approximately 11:00 a.m. on 5/12/2021, the facility Administrator was interviewed regarding the emergency contact information. The Administrator said he had neither reviewed nor signed off on the Emergency Officials contact information. The finding was discussed during an end of survey meeting that included the facility's administrative staff and the survey team.	E 031		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/11/2021 through 05/12/2021. One complaint was investigated during the survey. VA00050410 was unsubstantiated without deficient practice identified. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code report will follow.	F 000		

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F 000	Continued From page 3 The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of fourteen (14) current resident reviews, and two (2) closed record reviews.	F 000		
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have	F 565	**F565** **Corrective Action(s):** Facility administration has met with the resident council and addressed concerns brought up by the council regarding the timely answering of call bells. The resident council was made aware of the facility's plan to address the concern **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The administrator/designee Activity Director will meet with the Resident Council for notification of any other concerns the council has. **Systemic Change(s);** Facility policy and procedure was reviewed and no changes are warranted at this time. The Administrator will review the Resident Grievance & Concerns policy with all Department Head Staff to ensure they are aware of the grievance & Concern policy and the requirement that all grievances & Concerns related to their specific departments will be acted upon promptly and returned to the Activity Director for review with the administrator and the resident(s).	

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F 565	Continued From page 4 family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and facility document review, the facility staff failed to consider the views of the resident group and act promptly upon resident concerns/complaints of care and life in the facility for 5 months. Findings include: On 05/11/21 at 10:40 AM, Resident #52 [a resident who attends the group meeting regularly] was interviewed. Resident #52 was assessed with a cognitive score of 15, indicating the resident was cognitively intact. Resident #52 stated, that she felt there may be issues with staffing, as the call bell response was slow. Resident #52 stated that when you push the light, "you wait and wait and wait." At 11:45 a.m., the administrator stated that a group meeting with the survey team was declined by the resident council president. The resident council meeting minutes were reviewed from October 2020 through April 2021. The council meeting minutes documented concerns from residents regarding slow call bell response in October of 2020, November of 2020, January of 2021, February of 2021, and March 2021. On 05/11/21 at approximately 1:15 PM, Resident #32 [resident council president], who was assessed with a cognitive score of 15 [cognitively	F 565	**Monitoring:** The Administrator is responsible for maintaining compliance. The Activity Director will review resident council minutes monthly and the grievance log weekly to monitor for any resident concerns not acted upon. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date:**	06/15/2021

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F 565	Continued From page 5 intact] was interviewed. Resident #32 stated that she didn't think the facility was short on staff, but did voice concerns about slow call bell response times. Some concerns listed in the council minutes were reviewed with Resident #32. The slow call bell response was an ongoing concern. Resident #32 stated that if she rings her call bell and it takes a long time, that she will use her cell phone to call the nurse's station. The resident was asked, when the group meets and has concerns such as this, if there was anyone who follow's up with them to let them know what is being done to address the concern. Resident #32 stated that the AD [activity director] will follow up with her [the resident president] and let her know the concerns have been addressed. The resident stated that if concerns are brought to her, say in the hall by another resident then she, will in turn take those concerns to the AD. Resident #32 was not aware of any official way to track their [group or individual] concerns for progress and resolution to determine that the concerns were actually validated, addressed, and followed up on. On 05/12/21 at 9:30, the administrator stated that the AD was the designated person to help residents with the resident council. At approximately 3:00 p.m., the administrator, ADON (assistant director of nursing), the SW (social worker), QA (quality assurance) nurse, and corporate nurse were made aware of the concerns with the group meeting minutes indicating over 5 months of slow call bell response. The administrator stated that staff will talk to one another in the mornings during their stand up meetings and then stated that there was not an actual process to follow up with concerns	F 565		

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F 565	Continued From page 6 voiced by the residents in group. The ADON then stated that she received an email from the AD a while back, which included herself and the administrator regarding call bell response. The ADON stated that an inservice was completed. At approximately 3:30 p.m., the AD was interviewed. The AD stated that she writes down the resident concerns. The AD stated that usually if there is a problem with the kitchen, the kitchen staff will attend or if there is a problem with laundry, the laundry department will attend and try to resolve those issues directly. The AD also stated that she will communicate to the administrative staff via email regarding some concerns. The AD was unaware of any type of concern tracking that the administrative staff may have or use that would help to determine if concerns were being followed and/or tracked and what types of things that may have been put in place to ensure that the concerns were being addressed. On 05/12/21 at 5:00 p.m., the administrator, ADON (assistant director of nursing), the SW (social worker), QA (quality assurance) nurse, and corporate nurse were again made aware that concerns voiced by the residents were not being addressed. The administrator asked about the inservice. The administrator was made aware that the resident's had voiced concerns with slow call bell response times for 5 months and an inservice was completed in April. The inservice sheets that were presented were dated 04/20/21, 04/26/21, and 04/28/21 and documented for staff to answer call bells timely and that call bells should be in reach, and that ideally the call lights would be answered with in 3 to 5 minutes.	F 565		

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F 565	Continued From page 7 No further information and/or documentation was presented prior to the exit conference on 05/12/21.	F 565	**F641** **Corrective Action(s):** Resident #2 has had their most recent MDS corrected to accurately document the presence of a Level 11 PASRR. A copy of the Level 11 PASRR has been placed in the resident's clinical record. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a Level 11 PASRR may have potentially been affected. A 100% audit of all current resident MDS assessments will be completed by the MDS Coordinator and/or designee to ensure that MDS to identify residents at risk. All negative findings will be reported to the MDS department for immediate correction. A correction will be completed for each discrepancy identified on the most current MDS. **Systemic Change(s):** The MDS Coordinator has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include section A – Identification Information of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of the data in section A.	
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (minimum data set) was completed for Resident #2 regarding a Level II PASRR [preadmission screening and resident review]. Findings include: Resident #2 was admitted to the facility on 01/22/21. Diagnoses for Resident #2 included, but were not limited to: atrial fibrillation, diabetes mellitus, high blood pressure, history of UTI's[urinary tract infections], dysphagia, peg tube placement, behaviors, schizophrenia, and catatonic schizophrenia. The most recent full MDS was a five day admission assessment dated 01/29/21. This MDS assessed the resident with a cognitive score of 3, indicating the resident had severe impairment in daily decision making skills. The resident was also assessed as having schizophrenia in Section I. The resident was assessed in Section A. A1500. Preadmission Screening and Resident Review (PASRR) as no, indicating the resident did not have a serious	F 641		

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F 641	Continued From page 8 mental illness. In Section A. A1510. Level II Preadmission Screening and Resident Review (PASRR) the resident was not assessed, this area was blank on the MDS. This section was not completed and did not identify that Resident #2 had a serious mental illness. Resident #2's clinical record did not include any information for a Level I or Level II PASRR. On 05/12/21 10:06 AM, the SW [social worker] was interviewed regarding the above information. According to the SW this resident was admitted on 01/22/21 and was referred for a Level II PASRR prior to admission, which did not recommend outside psychiatric services. The SW was asked to present the information. On 05/12/21 01:10 PM, the SW presented the information that was in the resident's paper chart. Resident #2 had a Level I and a Level II completed prior to entry to the facility. The resident did not require any resources outside of the long term care facility. The SW was not sure why this was triggered. The SW was asked who completes the admission MDS for residents and where would information regarding PASRR come from. The SW stated that would be MDS and the information is usually kept by the admissions department as this is done prior to admission. The MDS Coordinator [MDSC] was interviewed on 05/12/21 at approximately 2:30 p.m. The MDSC looked up the MDS for Resident #2 and stated that the information in Section A1500. was incorrect and that section A1510. should have been completed. The MDSC stated that the	F 641	**Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:**	06/15/2021

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F 641	Continued From page 9 person who completed this MDS is no longer with the company and further stated that the information regarding PASRR is typically obtained from admissions and/or the business office because that information is obtained prior to admission and passed on to the MDS department for input into the resident's MDS. The MDSC also stated that staff would also ask to get that information from the SW or from the admission office to complete the MDS accurately. The MDSC stated that she could not speak to how the previous MDS person's process was or how she may have obtained information for MDS accuracy. No further information and/or documetnation was presented prior to the exit conference on 05/12/21.	F 641		

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 05/11/2021 through 05/12/2021. Corrections are required for compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 60 certified bed facility was 56 at the time of the inspection. The survey sample consisted of fourteen (14) current record reviews and two (2) closed record reviews.	F 000	**F001** **Resident Services** **12VAC5-371-250 (A).** **Please cross reference to F-641** *Cross Reference to POC for F Tag 641* **F641** **Corrective Action(s):** Resident #2 has had their most recent MDS corrected to accurately document the presence of a Level 11 PASRR. A copy of the Level 11 PASRR has been placed in the resident's clinical record.	
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 the Licensure of Nursing Facilities: 12VAC5-371-250 (A). Please cross reference to F-641.	F 001	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a Level 11 PASRR may have potentially been affected. A 100% audit of all current resident MDS assessments will be completed by the MDS Coordinator and/or designee to ensure that MDS to identify residents at risk. All negative findings will be reported to the MDS department for immediate correction. A correction will be completed for each discrepancy identified on the most current MDS. **Systemic Change(s):** The MDS Coordinator has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include section A – Identification Information of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of the data in section A.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Brad Stapp CNHA — TITLE: Administrator — (X6) DATE: 05/24/2021