PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495321	(X2) MULTIPI A. BUILDING B. WING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED  C  05/12/2021
	PROVIDER OR SUPPLIER	Terr	2	STREET ADDRESS, CITY, STATE, ZIP COD 205 HOUSTON STREET EAST LEXINGTON, VA 24450	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETIC
E 000	survey was conducted 5/12/2021. Corrected compliance with CF	Emergency Preparedness ted on 5/11/2021 through ions are required for FR 483.73, the Federal	E 000	Corrective Action(s): The Facility's Emergency Prepared Plan has been revised and updated ensure that the communication plate been reviewed.	to n has
E 029 SS=B	requirements for Er Long Term Care fac Development of Co CFR(s): 483.73(c)		E 029	Identification of Deficient Practice Corrective Action(s):  The entire Emergency Preparedness has been reviewed to identify any or incomplete required items in the	ss Plan missing
	emergency prepare that complies with F	st develop and maintain an edness communication plan Federal, State and local laws red and updated at least every or LTC).		Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident at Accident form will be completed finegative finding.	of nd
	by: Based on review of Preparedness Plan	of the facility's Emergency and staff interview, the facility the communication plan was		Systemic Change(s); Current facility policy & procedur ensuring that the Emergency Prepa Plan included policies and procedu ensure the communication plan is reviewed annually. No changes are	aredness ares that
300 0	The findings were:			warranted at this time. The Admir has reviewed the Emergency Preparedness Plan and reviewed th	nistrator
	of the Emergency P noted there was no	e communication plan portion reparedness Plan, it was documentation to indicate the n was reviewed and updated anual basis.		required items and training to be completed for compliance. All state be inserviced by the administrator/designee on the Eme Preparedness Plan.	< _
	At approximately 11 facility Administrator the communication reviewed the comm	.00 a.m. on 5/12/2021, the r was interviewed regarding plan. Asked if he had unication plan, the had reviewed it, but had not		Monitoring: The Administrator is responsible for maintaining compliance. The administrator will monitor and revenue Emergency Preparedness Plan quawith the QA committee to ensure this in compliance.	iew the rterly
	The finding was disc	cussed during an end of		Completion Date:	06/15/202

Any deficiency statement ending with an aste isk (\*) 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.

PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	AND REPORT OF THE PROPERTY OF	(X3) DATE SURVEY COMPLETED			
495321		B. WING			C <b>05/12/2021</b>	
		205	HOUSTON STREET			
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETION DATE	
survey meeting the administrative state Emergency Official CFR(s): 483.73(c)  [(c) The [facility] in emergency preparath the complies with and must be revied 2 years (annually plan must included (2) Contact inform (i) Federal, Stemergency preparation for the (ii) Federal, Stemergency preparation for the (ii) Federal, Stemergency preparation for the (iii) The State Agency.  [For ICF/IIDs at State Agency preparation for the (ii) Federal, Stemergency preparation for the (iii) Federal, Stemergency preparation for the (iii) Federal, Stemergency preparation for the (iiii) The State Agency.  [For ICF/IIDs at State Agency.	at included the facility's  ff and the survey team.  als Contact Information (2)  must develop and maintain an redness communication plan in Federal, State and local laws ewed and updated at least every for LTC).] The communication in all of the following: mation for the following: mate, tribal, regional, and local medness staff. Licensing and Certification  a of the State Long-Term Care material for the state conducts and certification  a federal for the state conducts and certification  a federal for the state conducts and certification  a federal for the following: material for the following: materia	E 029	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 Plhas been reviewed to identify any miss 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 eanegative finding.  Systemic Change(s); Current facility policy & procedure for ensuring that the Emergency Preparedness Plan contains accurate contact information is reviewed annually has be reviewed and no changes are warranted this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items are 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 Preparedness Plan quarterly	an ing ach ach at		
by:			Completion Date:		06/15/2021	
	SUMMARY S (EACH DEFICIEN REGULATORY OR REGULATORY OR REGULATORY OR Survey meeting the administrative statemergency Official CFR(s): 483.73(c)  [(c) The [facility] in emergency preparthat complies with and must be revied 2 years (annually plan must include (2) Contact inform (i) Federal, Stemergency prepare (ii) Other sour (ii) Federal, Stemergency prepare (iii) The State Agency.  (iii) The Office Ombudsman.  (iv) Other sour (iv) Other sour (iv) The State Agency prepare (iii) The State Agency prepare (iii) The State Agency.  (iv) The State Agency.  This REQUIREME	PROVIDER OR SUPPLIER  SE HALL LEXINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 1 survey meeting that included the facility's administrative staff and the survey team. 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.  *[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.  *[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.  *[For ICF/IIDs at §483.475(c):] (2) Contact information for the following:  (ii) The State Licensing and Certification Agency.  (iv) The State Protection and Advocacy Agency.  This REQUIREMENT is not met as evidenced	TOTAL CONTINUATION NUMBER:  495321  A BUILDING  B. WING  STR.  ST.  ST	A SULLDING   B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE 205 HOUSTON NY 24450	

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

Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 2 of 10



PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495321  NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL LEXINGTON		DENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING B. WING	LE CONSTRUCTION	C 05/12/2021	
		5 2	ETREET ADDRESS, CITY, STATE, ZIP CODE 205 HOUSTON STREET EAST LEXINGTON, VA 24450	1 03/1	2/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
E 031	Preparedness Pla staff failed to ensi	of the facility's Emergency an and staff interview, the facility ure Emergency Officials contact	E 031			
	reviewed on an a	E				
	information portion Preparedness Plat documentation to was reviewed and Review of the corleast one of the e	the Emergency Officials contact on of the Emergency an, it was noted there was no indicate the contact information d updated at least annually. Intact information revealed at mergency contacts listed was ed at the contact location.				
	facility Administra the emergency co Administrator said	11:00 a.m. on 5/12/2021, the stor was interviewed regarding ontact information. The dhe had neither reviewed nor Emergency Officials contact				<i>y</i> 15
F 000	survey meeting the administrative sta	discussed during an end of nat included the facility's aff and the survey team. NTS	F 000			
	survey was cond 05/12/2021. One during the survey unsubstantiated identified. Correct compliance with	d Medicare/Medicaid standard ucted 05/11/2021 through e complaint was investigated v. VA00050410 was without deficient practice tions are required for 42 CFR Part 483 Federal Long rements. The Life Safety Code				

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

Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 3 of 10



PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		B. WING	05/12/2021		
	PROVIDER OR SUPPLIE		20	TREET ADDRESS, CITY, STATE, ZIP CODE D5 HOUSTON STREET AST LEXINGTON, VA 24450	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
F 000	Continued From	page 3	F 000		
F 565 SS=E	at the time of the consisted of four reviews, and two Resident/Family CFR(s): 483.10(f) (5) The and participate ir (i) The facility mu group, if one existence reasonable steps to make resident upcoming meetin (ii) Staff, visitors, resident group of the respective group and the faproviding assistate requests that resident or family the grievances a groups concerning in the facility must implicate the consideration of the response and ration (B) This should readility must implicate the consistency of the	e resident has a right to organize in resident groups in the facility. Just provide a resident or family sts, with private space; and take is, with the approval of the group, its and family members aware of large in a timely manner.  To or other guests may attend in family group meetings only at	F 565	F565 Corrective Action(s): Facility administration has met wiresident council and addressed conbrought up by the council regarding timely answering of call bells. The resident council was made aware facility's plan to address the concellation of Deficient Practical Corrective Action(s): All other residents may have been potentially affected. The administrator/designee Activity D will meet with the Resident Councility motification of any other concerns council has.  Systemic Change(s); Facility policy and procedure was reviewed and no changes are warn this time. The Administrator will the Resident Grievance & Concern policy with all Department Head ensure they are aware of the grieve Concern policy and the requirement all grievances & Concerns related specific departments will be acted promptly and returned to the Activity and the requirement and the Activity and the requ	ncerns ing the ine of the ern ice(s) &  irrector cil for the  ranted at review ins Staff to rance & ent that I to their I upon vity
	participate in fan	e resident has a right to nily groups. e resident has a right to have		Director for review with the admi and the resident(s).	nistrator

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

Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 4 of 10



PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495321	B. WING		100	12/2021
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL LEXINGTON				STREET ADDRESS, CITY, STATE, ZIP COD 205 HOUSTON STREET EAST LEXINGTON, VA 24450	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 565	family member(s) representative(s) families or reside residents in the families are residents in the families are residents in the families are and resident facility document consider the view promptly upon recare and life in the Findings include:  On 05/11/21 at 1	or other resident meet in the facility with the ent representative(s) of other acility. ENT is not met as evidenced int interview, staff interview and review, the facility staff failed to ws of the resident group and act sident concerns/complaints of the facility for 5 months.	F 565	Monitoring: The Administrator is responsible maintaining compliance. The ADirector will review resident comminutes monthly and the grieval weekly to monitor for any reside concerns not acted upon. Any/all negative findings will to the Administrator for immedia corrective action to include an investigation.  Completion Date:	ctivity buncil ance log lent be reported	06/15/2021
	was interviewed. with a cognitive s resident was cog stated, that she f staffing, as the con Resident #52 sta "you wait and wa At 11:45 a.m., the	Resident #52 was assessed score of 15, indicating the nitively intact. Resident #52 elt there may be issues with all bell response was slow. It is that when you push the light, it and wait."  e administrator stated that a ith the survey team was declined				
	reviewed from O The council mee concerns from re response in Octo January of 2021, 2021. On 05/11/21 at a #32 [resident councerns]	incil meeting minutes were ctober 2020 through April 2021. Iting minutes documented esidents regarding slow call bell ober of 2020, November of 2020, February of 2021, and March pproximately 1:15 PM, Resident uncil president], who was cognitive score of 15 [cognitively				

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

Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 5 of 10



PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		E SURVEY IPLETED
		495321	B. WING			C 12/2021
	PROVIDER OR SUPPLIER  BE HALL LEXINGTO			STREET ADDRESS, CITY, STATE, ZIF 205 HOUSTON STREET EAST LEXINGTON, VA 24450	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 565	intact] was intervies she didn't think the did voice concerns times. Some concerns times. Some concerns slow call bell responsesident #32 state and it takes a long phone to call their was asked, when concerns such as follow's up with the being done to add #32 stated that the up with her [the reknow the concern resident stated that her, say in the hal will in turn take the Resident #32 was track their [group progress and resoconcerns were act followed up on.	ewed. Resident #32 stated that a facility was short on staff, but a shout slow call bell response cerns listed in the council ewed with Resident #32. The conse was an ongoing concern. The edit of the facility is station. The resident the group meets and has this, if there was anyone who can to let them know what is ress the concern. Resident the AD [activity director] will follow sident president] and let her a have been addressed. The fact if concerns are brought to by another resident then she, concerns to the AD. In not aware of any official way to or individual] concerns for oblution to determine that the treating the fact of the states of the stat	F	565		
	ADON (assistant of (social worker), Quand corporate nur concerns with the indicating over 5 n response. The act talk to one another stand up meetings	3:00 p.m., the administrator, director of nursing), the SW A (quality assurance) nurse, se were made aware of the group meeting minutes nonths of slow call bell liministrator stated that staff will r in the mornings during their and then stated that there was ess to follow up with concerns				

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

Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 6 of 10



PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495321		2012 C. 10 Sept.		COM	E SURVEY MPLETED C /12/2021
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL LEXINGTON			205 HOUSTON STREET	CODE	
(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFI TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
voiced by the restated that she walked administrator regard ADON stated that At approximately interviewed. The the resident condifference is a problem of the resident condifference in the resident condition of the resident concerns. The Aconcern tracking have or use that concerns were bounded and types of this place to ensure the addressed.  On 05/12/21 at 5 ADON (assistant (social worker), and corporate nucleon concerns voiced addressed. The inservice inservice was considered that the resident call bell responsionservice was considered that were 04/26/21, and 04/26/2	idents in group. The ADON then exceived an email from the AD a included herself and the arding call bell response. The tan inservice was completed.  3:30 p.m., the AD was AD stated that usually em with the kitchen, the kitchen if there is a problem with dry department will attend and try issues directly. The AD also will communicate to the aff via email regarding some. D was unaware of any type of that the administrative staff may would help to determine if eing followed and/or tracked and the aff to be any type of that the administrative staff may would help to determine if eing followed and/or tracked and the angent that the concerns were being at the concerns were being to p.m., the administrator, and in the concerns were being a doministrator asked about the doministrator was made aware that by the residents were not being a daministrator was made aware shad voiced concerns with slow as times for 5 months and an empleted in April. The inservice presented were dated 04/20/21, 1/28/21 and documented for staff	F5	565		
	PROVIDER OR SUPPLIE SE HALL LEXINGTO  SUMMARY S (EACH DEFICIEN REGULATORY OF  Continued From voiced by the res stated that she re while back, which administrator reg ADON stated that At approximately interviewed. The the resident cond if there is a proble staff will attend o laundry, the laund to resolve those is stated that she w administrative sta concerns. The A concern tracking have or use that concerns were be what types of thir place to ensure t addressed.  On 05/12/21 at 5 ADON (assistant (social worker), 0 and corporate nu concerns voiced addressed. The inservice. The a that the resident' call bell response inservice was co sheets that were 04/26/21, and 04 to answer call be should be in read	A95321  PROVIDER OR SUPPLIER SE HALL LEXINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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	REVIDER OR SUPPLIER SE HALL LEXINGTON  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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 was made aware that concerns voiced by the residents were not being addressed. 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	FORTECTION    A95321   B. WING	A BUILDING  495321  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 205 HOUSTON STREET 205 HOUSTON VA 24450  PROVIDERS PLAN DE CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  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. 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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 7 of 10



PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED		
				To the	C
	200 4050 00 01 001 150	495321	B. WING	REET ADDRESS, CITY, STATE, ZIP CODE	05/12/2021
	PROVIDER OR SUPPLIER  BE HALL LEXINGTON		20:	5 HOUSTON STREET AST LEXINGTON, VA 24450	-
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 641	presented prior to to 05/12/21.  Accuracy of Assess CFR(s): 483.20(g)  §483.20(g) Accuration The assessment management in resident's status.  This REQUIREME by:  Based on staff intereview, the facility saccurate MDS (min	ion and/or documentation was he exit conference on	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. Acopy of the Level 11 PASRR has been placed in the resident's clinical record.  Identification of Deficient Practice(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	nt A n d.
	PASRR [preadmiss review].  Findings include:  Resident #2 was a 01/22/21. Diagnos but were not limited mellitus, high blood UTI's[urinary tract tube placement, be catatonic schizoph  The most recent fuadmission assess MDS assessed the of 3, indicating the impairment in daily resident was also a schizophrenia in S assessed in Sectio Screening and Resident was also as assessed in Sectio Screening and Resident was also as assessed in Sectio Screening and Resident was also as assessed in Section Screening and Resident was also as assessed in Section Screening and Resident was also as assessed in Section Screening and Resident was also as assessed in Section Screening and Resident was also as assessed in Section Screening and Resident was also as as a section screening and Resident was also as a section section section was also as a section sectio	dmitted to the facility on sees for Resident #2 included, d to: atrial fibrillation, diabetes d pressure, history of infections], dysphagia, pegehaviors, schizophrenia, and		identify residents at risk. All negative findings will be reported to the MDS department for immediate correction. correction will be completed for each discrepancy identified on the most cur MDS.  Systemic Change(s): The MDS Coordinator has been inserviced by the Regional Nurse consultant on the proper assessment a coding of all areas of the MDS to incl section A – Identification Information the MDS. All comprehensive MDS's quarterly MDS's will now be reviewe 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.	A arrent and dude a of and and ad

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

Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 8 of 10



PRINTED: 05/18/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED C	
		495321	B. WING_	4		12/2021
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL LEXINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE 205 HOUSTON STREET EAST LEXINGTON, VA 24450		E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 641	Preadmission Scru (PASRR) the resident was blank on not completed and #2 had a serious resident #2's clini information for a L On 05/12/21 10:06 was interviewed reson 01/22/21 and w PASRR prior to acrecommend outsic SW was asked to On 05/12/21 01:10 information that w Resident #2 had a completed prior to resident did not resident did not resident did not resident was trigg. The SW was asked to SW was asked to the long term care why this was trigg.	Section A. A1510. Level II beening and Resident Review lent was not assessed, this if the MDS. This section was if did not identify that Resident mental illness.  Cal record did not include any level I or Level II PASRR.  AM, the SW [social worker] begarding the above information.  Whis resident was admitted was referred for a Level II dmission, which did not de psychiatric services. The present the information.  DPM, the SW presented the as in the resident's paper chart. A Level I and a Level II bentry to the facility. The equire any resources outside of a facility. The SW was not sure ered.  Ded who completes the	F6	Monitoring: The DON and RCC are response monitoring compliance. The Massessment audit will be complemently coinciding with the MI to monitor for compliance. All findings from the audits will be to the DON and RCC at the time discovery for immediate correct Aggregate findings will be report Quality Assurance Committeer for review, analysis, and recommendations for change in policy, procedure, and/or practice.  Completion Date:	DS eted DS calendar negative reported te of tion. orted to the monthly	06/15/2021
	information regard SW stated that we information is usu	or residents and where would ding PASRR come from. The buld be MDS and the ally kept by the admissions is done prior to admission.				
	on 05/12/21 at ap MDSC looked up stated that the info incorrect and that	proximately 2:30 p.m. The the MDS for Resident #2 and prmation in Section A1500. was section A1510. should have The MDSC stated that the				

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Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 9 of 10



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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			76 351.511.0			c
		495321	B. WING _		05/	12/2021
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL LEXINGTON		STREET ADDRESS, CITY, STATE, ZIP CODE  205 HOUSTON STREET  EAST LEXINGTON, VA 24450				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROIDEFICIENCY)	D BE	(X5) COMPLETION DATE
F 641	person who complete the company and finformation regardifrom admissions and because that informadmission and pastor input into the realso stated that stainformation from the office to complete MDSC stated that sprevious MDS person	age 9 eted this MDS is no longer with urther stated that the ng PASRR is typically obtained nd/or the business office nation is obtained prior to sed on to the MDS department sident's MDS. The MDSC ff would also ask to get that e SW or from the admission the MDS accurately. The she could not speak to how the son's process was or how she information for MDS	F 64	11		
	- A control of the co	ion and/or documetnation was the exit conference on				

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Event ID: URDB11

Facility ID: VA0113

If continuation sheet Page 10 of 10



State of Virginia STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING VA0113 05/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 HOUSTON STREET HERITAGE HALL LEXINGTON EAST LEXINGTON, VA 24450 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 000 Initial Comments F 000 F001 Resident Services An unannounced biennial State Licensure 12VAC5-371-250 (A). Inspection was conducted 05/11/2021 through Please cross reference to F-641 05/12/2021. Corrections are required for Cross Reference to POC for F Tag 641 compliance with Virginia Rules and Regulations for the Licensure of Nursing Facilities. F641 Corrective Action(s): The census in this 60 certified bed facility was 56 Resident #2 has had their most recent at the time of the inspection. The survey sample MDS corrected to accurately document consisted of fourteen (14) current record reviews the presence of a Level 11 PASRR. A and two (2) closed record reviews. copy of the Level 11 PASRR has been placed in the resident's clinical record. F 001 Non Compliance F 001 Identification of Deficient Practice(s) and Corrective Action(s): The facility was out of compliance with the following state licensure requirements: All other residents with a Level 11 PASRR may have potentially been affected, A 100% audit of all current This RULE: is not met as evidenced by: The facility was not in compliance with the resident MDS assessments will be following Virginia Rules and Regulations for the completed by the MDS Coordinator Licensure of Nursing Facilities: and/or designee to ensure that MDS to identify residents at risk. All negative 12VAC5-371-250 (A). findings will be reported to the MDS department for immediate correction. A Please cross reference to F-641. 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

899