	-	D HUMAN SERVICES					FORM	APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES					OMB NC	<u>). 0938-0391</u>
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		· /	PLE CONSTRUCTIO				LETED	
		495135	B. WING _					C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP COD	E		
HERITAGE	E HALL BIG STONE GAP			2045 VALLEY V				
				BIG STONE G	AP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EA	PROVIDER'S PLAN OF CO CH CORRECTIVE ACTION SS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE		(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00				
F 000	survey was conducted 05/12/2021. The faci compliance with 42 C	lity was in substantial FR Part 483.73, J-Term Care Facilities.	F0	00				
	survey was conducter Four (4) complaints w survey. Corrections a	-						
F 578 SS=D	135 at the time of the consisted of 27 current closed record reviews	ntnue Trmnt;FormIte Adv Dir	F 5	78				
	discontinue treatment	ht to request, refuse, and/or , to participate in or refuse imental research, and to directive.						
	construed as the right the provision of medic	g in this paragraph should be t of the resident to receive cal treatment or medical dically unnecessary or						
	requirements specifie subpart I (Advance D (i) These requirement	acility must comply with the d in 42 CFR part 489, irectives). is include provisions to SUPPLIER REPRESENTATIVE'S SIGNATUR			TITLE			(X6) DATE

08/02/2021

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.

		ID HUMAN SERVICES				FORM	M APPROVED D. 0938-0391		
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED		
		495135	B. WING			CORRECTION TION SHOULD BE C THE APPROPRIATE			
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE				
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 578	inform and provide we residents concerning medical or surgical tre- resident's option, form (ii) This includes a we facility's policies to im and applicable State I (iii) Facilities are perm- entities to furnish this legally responsible for requirements of this s (iv) If an adult individu- time of admission and information or articular has executed an adva- may give advance dir- individual's resident re- with State Law. (v) The facility is not re- provide this information or she is able to recei Follow-up procedures the information to the appropriate time. This REQUIREMENT by: Based on staff intervi- review, facility staff fa- right to formulate an a to ensure the correct residents, Resident # The findings included For Resident #116, fa- the correct code statu- Resident # 116's diag	ritten information to all adult the right to accept or refuse eatment and, at the nulate an advance directive. itten description of the plement advance directives law. nitted to contract with other information but are still r ensuring that the section are met. ual is incapacitated at the d is unable to receive the whether or not he or she ance directive, the facility ective information to the epresentative in accordance relieved of its obligation to on to the individual once he ve such information. a must be in place to provide individual directly at the the is not met as evidenced iew and clinical record iled to ensure the resident's advanced directive by failing code status for 1 of 27 116.	F	578					

Facility ID: VA0106

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 11/05/2021 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMPI	SURVEY LETED
		495135	B. WING		_	05/ [,]	C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
HERITAGI	E HALL BIG STONE GAP			045 VALLEY VIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 578	COVID-19, Schizophr Disorder Current Epis Psychotic Features, L Behavioral Disturband Convulsions, Unspeci Atherosclerotic Heart Artery without Angina The most recent adm set) with an ARD (ass 4/02/21 assigned the interview for mental s section C, Cognitive F Resident #116's clinic physician's order date Resuscitate (DNR)". provide a completed I #116. On 5/06/21, the admin with a copy of a verba 5/06/21 stating "Resid progress note dated 5 "Spoke with (physicia status for this residen obtained". On 5/11/21 at 9:16 an DON (director of nurs was admitted with a E completed DNR form. with the nurse that wr said they must have s stated that on 5/06/21 Resident #116's adult	renia Unspecified, Bipolar sode Manic Severe with Unspecified Dementia with the Unspecified fied Atrial Fibrillation, and Disease of Native Coronary Pectoris. ission MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 5 out of 15 in Patterns. al record included an active ed 3/26/21 stating "Do Not The Facility was unable to DNR form for Resident histrator provided surveyor al physician's order dated dent is Full Code". A nursing 5/06/21 3:32 pm states in name omitted) re full code t at this time verbal order h, surveyor spoke with the ing) who stated the resident DNR order but did not have a DON stated they spoke ote the order and the nurse seen it somewhere. DON , the facility contacted sibling who stated they did to be a DNR and the order	F 578				

Facility ID: VA0106

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		495135	B. WING			C 05/12/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
	Surveyor requested a policy entitled "Do No states in part: "2. A Do Not Resusci be completed and sig Physician and resider surrogate, as permitte in the front of the resid a. Use only Sta b. If no State for facility-approved form On 5/12/21 at 12:30 p administrator, DON, r nurse consultant #2 o #116 having an order completed DNR form. No further information presented to the survice conference on 5/12/2 Notify of Changes (Inj CFR(s): 483.10(g)(14) S483.10(g)(14) Notified (i) A facility must imm consult with the reside consistent with his or representative(s) whee (A) An accident involver (B) A significant chan- mental, or psychosoc deterioration in health status in either life-thr clinical complications	nd received the facility t Resuscitate Order" which tate (DNR) order form must ned by the Attending at (or resident's legal ed by State law) and placed dent's medical record. the-approved DNR forms. orm is required, use ." orm, surveyor notified the nurse consultant #1, and f the concern of Resident for DNR without a regarding this issue was ey team prior to the exit 1. fury/Decline/Room, etc.))(i)-(iv)(15) cation of Changes. ediately inform the resident; ent's physician; and notify, her authority, the resident in there is- ring the resident which as the potential for requiring i; ge in the resident's physical, ial status (that is, a i, mental, or psychosocial eatening conditions or		578				

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP		
		495135	B. WING			05/12/2021		
NAME OF P	ROVIDER OR SUPPLIER	L			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>		
HERITAG	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
F 580	a need to discontinue treatment due to adve commence a new form (D) A decision to trans- resident from the facil §483.15(c)(1)(ii). (ii) When making noti (14)(i) of this section, all pertinent information is available and provide physician. (iii) The facility must a resident and the reside when there is- (A) A change in room as specified in §483.1 (B) A change in reside State law or regulation (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a compo- that is a composite di §483.5) must disclose its physical configurat locations that comprise part, and must specify room changes betwee under §483.15(c)(9). This REQUIREMENT by: Based on staff interv	e an existing form of erse consequences, or to m of treatment); or sfer or discharge the lity as specified in fication under paragraph (g) the facility must ensure that on specified in §483.15(c)(2) ded upon request to the also promptly notify the dent representative, if any, or roommate assignment I0(e)(6); or ent rights under Federal or ns as specified in paragraph record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations f is not met as evidenced iews and clinical record ed to notify providing and/or <i>v</i>) for medication not	F	580				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		495135	B. WING				_ 12/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	-	
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 580	twenty-seven residen 1. For Resident #121 the medical provider a representative of a sig- identified on 12/03/20 psychiatric nurse prac- the resident's suicide failed to notify the phy- to send the resident b suicide attempt on 4/3 Resident #121's diago- diagnoses, which incl Mood Disorder due to Condition, Schizoaffe Major Depressive Dis- Unspecified, Unspeci Behavioral Disturband Unspecified Cerebroy B12 Deficiency Anem- Diabetes Mellitus with Unspecified. The most recent quar- set) with an ARD (ass 4/02/21 assigned the interview for mental s section C, Cognitive F Swallowing/Nutritional coded as having a we the last month or loss months while not on a weight-loss regimen. A review of Resident revealed the following 10/01/20 120.0 lbs., 1 94.0 lbs., 2/03/21 94.	ts (#121). , facility staff failed to notify and the resident gnificant weight loss b, failed to notify the cititoner and psychologist of attempt on 4/30/21, and ysician of the ER's decision back to the facility following 30/21. mosis list indicated uded, but not limited to b Known Physiological ctive Disorder Unspecified, order Recurrent fied Dementia with ce, Dysphagia following vascular Disease, Vitamin ia Unspecified, and Type 2 n Diabetic Neuropathy terly MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 3 out of 15 in Patterns. In section K, il Status, Resident #121 was sight loss of 5% or more in of 10% or more in the last 6 a physician-prescribed	F	580				

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	D: 11/05/2021 APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			SURVEY LETED
		495135	B. WING		_		
NAME OF PF	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HERITAGE	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	A dietician progress n states in part, "(He/sh BID (twice a day) and times a day). (He/sh soft diet with ground r weight): 95# 12/3 wh and 180 days. Supple Will monitor for addition Surveyor was unable provider or resident re- the 25 lb. weight loss On 5/12/21 at 10:36 a DON (director of nurs not find physician or r of the weight loss. Surveyor requested a policy entitled, "Weigh Intervention" which st for weight loss or imp multidisciplinary effort Physician, nursing sta Consultant Pharmacias resident's legal surrog A nursing progress no states "this nurse was nursing assistant) wh answer call bell call b and was laying behind	lity COVID-19 outbreak. ote dated 12/22/20 5:14 pm le) is receiving Prostat 30 ml Medpass 120 ml QID (four e) is on a regular mechanical meat. CBW (current body ich is a significant loss x 90 ements remain appropriate. onal needs". to locate documentation of from 10/01/20 to 12/03/20. am, surveyor spoke with the ing) who stated they could esponsible party notification ates in part "Care planning aired nutrition will be a t and will include the aff, the Dietitian, the st, and the resident or gate". but dated 2/04/21 8:48 pm is notified by cna (certified en (he/she) went in to ell was pulled out of the wall d and across res (resident) but this res stated (he/she) t way."	F 580				
		progress note dated es "this nurse went in to talk					

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/05/2021 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_	(05/ [.]	; 12/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
HERITAG	E HALL BIG STONE GAP			045 VALLEY VIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	had call bell around n didn't want to hurt (hir didn't know it was tha [sp] (he/she) had prev to hurt (himself/herse to er res stated (he/sh saying that that I'm lib because I say it does Resident #121 was re 2/27/21 following inpa- (facility name omitted A nursing progress no states "this nurse was cna that res roommat had put call bell arour nurse spoke with res was trying to kill herse when it started to hurd 9:44 pm states "Upon injuries noted by this transported to the loc. The After Visit Summa omitted) Emergency I states in part, "Follow medicine on an outpa suicidal precautions". Resident #121 was se (nurse practitioner) th the progress note stat patient had made a si call bell around (his/h E.R. r/t suicide attempt the facility from (facility	a going to er where (he/she) eck res stated (he/she) mself/herself) that (he/she) t way I explained to res were viously said (he/she) wanted lf) that (he/she) needs to go he) didn't even remember bel to say anything just n't mean I need it". eadmitted to the facility on attient psychiatric care at). but dated 4/11/21 7:46 pm is setting at desk was told by e had told (him/her) that res hd (his/her) neck when this (he/she) stated (he/she) elf but (he/she) stopped t". Addendum dated 4/11/21 assessment of res o [sp] nurse". Resident #121 was al ER at 7:58 pm. ary from (facility name Department dated 4/11/21 -up with behavioral tient basis. Maintain	F 580				

Facility ID: VA0106

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	MEDICARE & M	D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE			FORM	0: 11/05/2021 1APPROVED . 0938-0391 SURVEY
AND PLAN OF CORREC		IDENTIFICATION NUMBER:	. ,			COMPI	
		495135	B. WING		_	05/ [,]	C 12/2021
NAME OF PROVIDER	OR SUPPLIER		5	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
HERITAGE HALL I	BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
in bed CNA). suicide remen of self depres include Reside 7:46 p around intent confro of doir wantee reques persor for a o attenti- be a s out". A nurs states Reside eyes o Reside gersor for a o attenti- be a s out".	Discussed with e yesterday. Pt nber that, I'm gla harm/suicidal ic ssed; denies an e "continue cons ent #121 was se ologist via telefor rom the visit stat ent with progress om, finding Resid d (his/her) neck. or plan or streng onted, Resident in g that""(He/s d to die but den sted that with ea n be appointed, one on one with ion and support. suicide gesture v sing progress not in part "Late not ent was found in closed with call I ent was turning ntied call light co d to die and that on. Vitals were is a, Resp 18, Tem calling transport ". Subsequent p am states in pa	e 8 tly constant observation by h patient (his/her) attempt at verbalized, 'I don't ad I don't.' Denies thoughts deations. Endorses xiety". Recommendations stant observation". een by the licensed ealth on 4/14/21, progress tes in part, "Approached as note report of 4/11/21, dent with call bell cord . However, no evidence of gth to tighten cord. When said (he/she) had no recall she) said (he/she) still ied intent or plan""It is ach shift change, a staff who would spend 10 mins. Resident for positive . Incident of 4/11 appears to w/o intent or plan to carry be dated 5/01/21 12:33 am ote for 2158 (9:58 pm): n room laying in bed with light tied tightly around neck. blue and when released ord, resident stated (he/she) t I had not found (him/her) taken B/P 118/76, Pulse 84, p 98.4. Placed aide 1 on 1 t and notifying doctor and progress note dated 5/01/21 rt "late note for 2232 (10:32 As resident was leaving	F 580				

Facility ID: VA0106

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	-	D HUMAN SERVICES					FORM	D: 11/05/2021
STATEMENT C	S FOR MEDICARE & I OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		495135	B. WING			_		C 12/2021
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
HERITAGE	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE	219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	didn't know why (he/s that". The After Visit Summa omitted) Emergency I states in part, "Patien" the severity of (his/he really decide to comm so disabled (bed bour to act on a suicidal im have one. There is no (his/her) acting out an evaluation and treatm any good. (He/she) d custody at a psych fac There is just no value call cord from (his/her omitted) is a safe and stay". Resident #121 was set telehealth visit with th 5/05/21, the progress "(He/she) added 'I'm of don't want to live'(express low will to live to take (him/her), whic active suicidal ideation time." The progress r documentation of the the resident wrapped their neck. Surveyor of documentation that th of the 4/30/21 inciden	(his/her) neck and (he/she) he) would do something like ary from (facility name Department dated 4/30/21 t is not truly 'suicidal' due to r) dementia. ((He/she) can't it suicide). And (he/she) is hd) that (he/she) is not able pulse even if (he/she) did o known treatment for d having another psych ent would not do (him/her) oes not need protective cility to prevent suicide. in this. Please remove the) reach. (Facility name good place for (him/her) to een for their weekly e licensed psychologist on note states in part, depressed out of my mind. I He/she) continues to a in terms of praying for god ch is differentiated from n, intent, or plan at this note does not include any incident on 4/30/21 when the call bell cord around could not locate e psychologist was notified t.	F	580				
	psychologist by leavin							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/05/2021 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	-	(X3) DATE COMPI	LETED
		495135	B. WING		_	05/ [,]	, 12/2021
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HERITAG	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE			
	1			BIG STONE GAP, VA 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 580	Continued From page on 5/12/21 the calls h		F 58	30			
	Surveyor was unable the resident's clinical being notified followin last documented prog psychiatric NP was da attempted to contact is 5/05/21, 5/06/21, and mailbox was full each unable to leave a mee On 5/06/21 at 2:59 pr administrator and ask discussed the resider resident's physician of assistance, administration has but I haven't". At they had just spoken and they are okay wit now but if it happens provide services then progress note written 3:16 pm states "This omitted), Medical Dire regards to resident's pr resident being found pr resident's neck. (Nar this time (he/she) is c being in facility, howe to ER from this facility attempt to harm self a crisis services for resident will request discharge not being able to prove resident seems to need	to locate documentation in record of the psychiatric NP ig the 4/30/21 incident. The press note from the ated 4/28/21. Surveyor the psychiatric NP on 5/10/21, however, the voice time and surveyor was ssage. In, surveyor spoke with the red if the facility had it's current situation with the r the medical director for ator stated "maybe the DON 3:15 pm, the DON stated with the medical director h the resident being here again and the ER will not discharge (him/her). A by the DON dated 5/06/21 nurse spoke with (name ector of this facility in multiple discharges to ER d/t with cord wrapped around ne omitted) advised that at omfortable with resident ver, if resident is discharged v for this or any other and ER does not provide ident that (name omitted) e from this facility d/t facility vide the extra services					

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		495135	B. WING						
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE				
HERITAG	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
F 580	health evaluation. Su documentation that the assessed (him/her) for 4/30/21. On 5/10/21 surveyor spoke with F via telephone. The pl been in the facility in the they were aware of the Resident #121. Physe problem with the ER at them. The physician impossible to get an at psychiatrist. Surveyor feel that Resident #12 they stated "that's a to "guarded yes" and "or On 5/10/21 at 1:20 pr facility medical director #121's history of suici- director stated that he Resident #121 as (he patient but the facility resident was sent out director stated that the in the crisis team for to medical director also that an outpatient psy (him/her)". They also watch (him/her) carefi reach, continue to see practitioner, and set si check on (him/her). On 5/12/21 at 12:30 p administrator, DON, ri nurse consultant #2 to	a 5/01/21 without a mental inveyor could not locate he resident's physician had ollowing the incident on at approximately 3:30 pm, Resident #121's physician hysician stated they had the last 2 weeks, they stated he three suicide attempts by ician stated they have a and have no control over further stated it is almost appointment with a r asked the physician if they 21 is safe in the facility and bugh one" but it is a verall I think it is". In surveyor spoke with the pr concerning Resident ide attempts. The medical e was not very familiar with /she) is (name omitted) did notify them when the on 5/01/21. The medical ey do not think the ER called the resident on 5/01/21. The stated that it is "very unlikely	F	580					

Facility ID: VA0106

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		D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED		
		495135	B. WING				C 12/2021		
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE				
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 580 F 607 SS=E	to December 2020 an facility failing to follow with the physician, ps and the medical direct No further information presented to the survice conference on 5/12/2 Develop/Implement A	tative notification of . weight loss from October d of the concern of the -up and coordinate care ychologist, psychiatric NP, tor. regarding this issue was ey team prior to the exit 1. buse/Neglect Policies		580 607					
	§483.12(b) The facility implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establis to investigate any suc §483.12(b)(3) Include paragraph §483.95, This REQUIREMENT by: Based on staff intervi and facility document failed to obtain verific Department of Health 1 (Employee # 8) of 8 1(Employee # 20) of Assistants and failed expired dates on three # 19) of 8 Registered re-verify the expired lit	y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures th allegations, and training as required at is not met as evidenced we, employee record review ation review, the facility staff ation of licensure from the Professions prior to hire for Registered Nurses, for 6 Certified Nursing to re-verify licensure after e (Employees # 6, # 17 and							

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		495135	B. WING				C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	12/2021
				2	2045 VALLEY VIEW DRIVE		
HERITAG	E HALL BIG STONE GAP			E	BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	facility staff failed to o Background Check fo Unlicensed Nurses Ai 24) of 6 Licensed Pra Criminal Background The Findings included 1. For Employee # 8, obtain licensure verifi On 5/5/2021- 5/7/202 of employee records. Review of the person was conducted and re hired on 12/7/2020 as Employee # 8's Regis verified by the facility Health Professions un p.m.), after her date of On 5/10/2021 at apprinterview was conduce Resources Director wilcense for Employee date of hire. She statt licenses would be ver hire. An interview was Administrator (Employee cate of hire. She statt licenses would be ver hire. An interview was for license for Employee date of hire. She statt licenses would be ver hire. An interview was for license for Employee date of hire. She statt licenses would be ver hire and re-verified up	btain a Criminal r one (Employee # 22) of 4 de and one (Employee # ctical Nurses to obtain a Check prior to hire. d: the facility staff failed to cation prior to hire. 1, a review was conducted nel file for Employee # 8 evealed Employee # 8 was a the Director of Nursing. stered Nurse license was not staff with the Department of ntil 12/8/2020 at 13:38 (1:38 of hire. oximately 3:58 p.m., an ted with the Human ho confirmed that the # 8 was verified after the ed the expectation was that ified and current prior to as conducted with the facility yee A) who stated the censes to be verified prior to	F	607			

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° '	E CONSTRUCTION			LETED
		495135	B. WING		_		C 12/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		_	
HERITAGE	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Administrator stated h the facility's policy. T background checks sh new employees prior The facility policy on A and Reporting, Revise 05/11/2021. On page written: " The components of prohibition plan, The 3. Not employ or other who: a. Have been found g exploitation, misappro- mistreatment by a cou- b. Have had a finding aide registry concerni- exploitation, misappro- c. Have a disciplinary or her professional lic body as a result of ab misappropriation of pr d. Background, refered checks should be com- to or at the time of em- administration, in accu- state and federal regu- knowledge that an em- certification is in quess information to the Adr	s was requested. The ne would submit a copy of he Administrator stated hould be completed on all to the hire date. Abuse, Neglect, Exploitation ed 11/2016 was reviewed on e 2 of 5 under the topic was the facility's abuse Facility Must: wise engage individuals guilty of abuse, neglect, opriation of property or urt of law; g entered the State nurse ng abuse, neglect, opriation of property. v action in effect against his ense by a state licensure use, neglect, exploitation, roperty. ences, and credentials' iducted on employees prior inployment, by facility ordance with applicable ulations . Any person having inployee's license or tion should report such	F 607	7			

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		ID HUMAN SERVICES					FORM	D: 11/05/2021 APPROVED D. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			i í		CONSTRUCTION	(X3) DATE SURVI COMPLETED		SURVEY PLETED
		495135	B. WING					C 12/2021
NAME OF PF	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE	E, ZIP CODE		
HERITAGE	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PL (EACH CORRECTI) CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE D TO THE APPROPRIA ICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page No further information		F	607				
	have a license verifica	, the facility staff failed to ation check with the Professions (DHP) prior to						
	Certified Nursing Assiverification at the time documents presented revealed Employee # by the facility staff with Professions until 5/5/2 according to the "Lice On 5/10/2021 at 3:58 conducted with the He who stated she could verification document The Human Resource looked in a binder wh Resources Director ke documents but was u documentation. The Human Resource expectation was that and current prior to hi conducted with the far (Employee A) who state	ere the previous Human ept copies of some nable to find the missing es Director stated the licenses would be verified re. An interview was						
	upon expiration.							

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CENTER STATEMENT (AND PLAN OF NAME OF P	-	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	· /	ING _ S 2	E CONSTRUCTION	FORM OMB NC (X3) DATE COMP	D: 11/05/2021 MAPPROVED D: 0938-0391 SURVEY PLETED C 12/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 607	conducted with the fa informed of the issue. policy on Hiring, Back Files and Termination Administrator stated h the facility's policy. T background checks si new employees prior The facility policy on A and Reporting, Revise 05/11/2021. On page written: " The components of prohibition plan, The 3. Not employ or othe who: a. Have been found g exploitation, misappro mistreatment by a cou b. Have had a finding aide registry concerni exploitation, misappro c. Have a disciplinary or her professional lic body as a result of ab misappropriation of pr d. Background, refere checks should be com to or at the time of em administration, in acc state and federal regu	0 p.m., an interview was cility Administrator who was . A copy of the facility's kground Checks, Personnel is was requested. The ne would submit a copy of the Administrator stated hould be completed on all to the hire date. Abuse, Neglect, Exploitation ed 11/2016 was reviewed on e 2 of 5 under the topic was the facility's abuse Facility Must: erwise engage individuals guilty of abuse, neglect, opriation of property or urt of law; g entered the State nurse ing abuse, neglect, opriation of property. y action in effect against his sense by a state licensure buse, neglect, exploitation, roperty. ences, and credentials' nducted on employees prior inployment, by facility ordance with applicable ulations . Any person having inployee's license or stion should report such	F	607			

Facility ID: VA0106

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	-	ID HUMAN SERVICES				FOR	M APPROVED 0. 0938-0391			
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED			
		495135	B. WING			C 05/12/2021				
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE					
HERITAG	E HALL BIG STONE GAP				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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 607	Continued From page	e 17	F	607	7					
	debriefing, the facility	-								
	re-verify the license a Review of the person revealed that Employ 1/21/2020 as a Regis of the Staff Developm time of hiring, Employ license was listed as	tered Nurse in the position nent Coordinator. At the /ee 6's Registered Nurse expiring on 1/31/2021. Her rified by the facility staff with ealth Professions until								
	She stated that she d documentation that th after the date it was li	n 5/10/2021 at 3:58 p.m. id not see any ne license had been verified isted to expire so she hen she compiled the list of								
	Resources Director w in that position for a c stated she had develo	viewed with the Human who stated that she had been couple of months. She oped some procedures to ation of all of the licenses e.								

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495135	B. WING				_ 12/2021
	ROVIDER OR SUPPLIER E HALL BIG STONE GAP		•	2	STREET ADDRESS, CITY, STATE, ZIP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 607	notice every month of were due to expire. T visible for employees Managers/supervisors of employees who ne licenses. The Humar verify the renewal, pri place a copy in the Pe employee's file. On 05/10/2021 at 4:3 conducted with the fa informed of the issue. conducted with the fa (Employee A) who sta	es Director stated the partment would send a f employees whose licenses The notice would be readily to view. The Unit s would be informed as well eded to renew their n Resources Director would int out a new copy, and ersonnel Binder and in the 80 p.m., an interview was cility Administrator who was . An interview was	F	607			
	 debriefing, the facility informed of the finding he had no questions a No further information 4. For Employee # 1¹ re-verify the license a 						

Facility ID: VA0106

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	MENT OF HEALTH AN S FOR MEDICARE & I					FORM): 11/05/2021 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_	05/ [,]	; 12/2021
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HERITAG	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	Continued From page	- 19	F 607				
	Registered Nurse. At was listed as expiring was not re-verified by Department of Health at 18:39 (6:39 p.m.). The issue was review Resources Director of She stated that she d documentation that th after the date it was liverified the license whe employee records for The findings were rev Resources Director w in that position for a c stated she had develor make sure the verifica were renewed on time The Human Resource Human Resource dep notice every month of were due to expire. T visible for employees	n 5/10/2021 at 3:58 p.m. id not see any e license had been verified sted to expire so she nen she compiled the list of review. iewed with the Human ho stated that she had been ouple of months. She oped some procedures to ation of all of the licenses e. es Director stated the partment would send a femployees whose licenses the notice would be readily					
	verify the renewal, pri place a copy in the Pe employee's file. On 05/10/2021 at 4:30	Resources Director would nt out a new copy, and ersonnel Binder and in the D p.m., an interview was cility Administrator who was An interview was					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ECONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		495135	B. WING			_		C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, S	TATE, ZIP CODE	•	
HERITAGI	E HALL BIG STONE GAP	•			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	licenses to be verified upon expiration. On 5/12/2021 at 11:0 debriefing, the facility	ated the expectation was for a prior to hire and re-verified 5 a.m. during the end of day Administrator was again gs. The Administrator stated about the findings.	F	607				
	re-verify the license a Review of the person revealed: Employee # 19 was h Registered Nurse. At was listed as expiring was not re-verified by Department of Health at 18:39 (6:39 p.m.).	9, the facility staff failed to fter the date of expiration. nel file for Employee # 19 hired on 3/27/2020 as a t the time of hire, her license on 4/30/2021. Her license the facility staff with the Professions until 5/5/2021						
	She stated that she d documentation that th after the date it was li	n 5/10/2021 at 3:58 p.m. id not see any ne license had been verified sted to expire so she hen she compiled the list of						

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		495135	B. WING				C / 12/2021
	ROVIDER OR SUPPLIER	,	•	:	STREET ADDRESS, CITY, STATE, ZIP CODE 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 PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 607	Continued From page	e 21	F	607	7		
	Resources Director w in that position for a c stated she had develo make sure the verifica were renewed on time The Human Resource Human Resource dep notice every month of were due to expire. T visible for employees	es Director stated the partment would send a f employees whose licenses The notice would be readily to view. The Unit s would be informed as well					
	verify the renewal, pri	n Resources Director would int out a new copy, and ersonnel Binder and in the					
	4:30 p.m. on 5/10/202 conducted with the fa (Employee A) who sta	s notified of the issue at 21. An interview was cility Administrator ated the expectation was for d prior to hire and re-verified					
	debriefing, the facility	5 a.m. during the end of day y Administrator was again gs. The Administrator stated about the findings.					
	No further informatior	n was provided.					

Event ID: OGAZ11

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391		
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SU COMPLE C			
		495135	B. WING			05/12/2021			
NAME OF PI	ROVIDER OR SUPPLIER	l		ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		-		
HERITAGI	E HALL BIG STONE GAP	,			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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE		
F 607	Continued From page	2 22	F	607	7				
	re-verify the license a	4, the facility staff failed to fter the date of expiration.							
	Review of the person revealed:	nel file for Employee # 24							
	Licensed Practical Nu verified prior to hire a 1/31/2021. Her licens facility staff with the D Professions until 5/5/ Employee # 24 worke	hired on 12/31/2019 as a surse. Her license was nd listed as expiring on se was not re-verified by the Department of Health 2021 at 18:49 (6:49 p.m.). ad for over 3 months without renewal by facility staff.							
	She stated that she d documentation that th after the date it was li	n 5/10/2021 at 3:58 p.m. id not see any ne license had been verified isted to expire so she hen she compiled the list of							
	Resources Director w in that position for a c stated she had develo	viewed with the Human vho stated that she had been couple of months. She oped some procedures to ation of all of the licenses e.							
	notice every month of	partment would send a f employees whose licenses The notice would be readily							

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING			_		C 12/2021
NAME OF PF	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, ST			
HERITAGE	E HALL BIG STONE GAP	1			15 VALLEY VIEW DRIVE G STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	of employees who ne licenses. The Humar verify the renewal, pri	s would be informed as well	F 6(57				
	4:30 p.m. on 5/10/202 conducted with the fa (Employee A) who sta							
	debriefing, the facility	5 a.m. during the end of day y Administrator was again gs. The Administrator stated about the findings.						
	No further information	ı was provided.						
	and facility document failed to ensure a crin completed for two (Er 29 employees in the F sample. The findings included	ew, employee record review, ation review, the facility staff ninal background check was mployees # 22 and # 24) of Employee Records Check : 2, the facility staff failed to						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391	
STATEMENT O	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495135	B. WING		_		C 12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	-		
HERITAGE	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 607	Continued From page	24	F 607	7				
	ensure a criminal bac completed at the time							
	On 05/5/2021- 05/07/ Reviews were conduc	2021, Employee Record cted.						
	Unlicensed Aide and Nursing Assistant classical stress of the second str	red on 02/10/2020 as an enrolled in the Certified ss. According to the Human he entire personnel file was						
	spreadsheet list of all 2019 revealed Emplo and disposition listed	dates of hire were listed as						
	Resources Director of The Human Resource # 22's Personnel file v	ducted with the Human n 05/10/2021 at 3:58 p.m. es Director stated Employee was empty and did not have e dates of employment at						
	been in her position for She stated she contain Resources Director to happened to Employee informed "the entire fi	es Director stated she had or only a couple of months. cted the previous Human o inquire about what ee 22's record and was le was sent" to their sister se 22 transferred there.						
	was informed by the s was no record of any	an Resources Director, she sister facility's staff that there records being sent there. t copies of documents from						

Facility ID: VA0106

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	-	ID HUMAN SERVICES				FORM	MAPPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA					LE CONSTRUCTION	OMB NO. 0938-0391		
						(X3) DATE SURVEY COMPLETED		
			A. DOILD				с	
		495135	B. WING					
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00,	12/2021	
					2045 VALLEY VIEW DRIVE			
HERITAG	E HALL BIG STONE GAP				BIG STONE GAP, VA 24219			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD E		COMPLETION DATE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	AIE	DALL	
			-					
F 607	Continued From page	25	E	607	7			
1 007	- 15			00	/			
		yment at their facility. The irector stated she knew						
		t suffice for the current						
		o show what was sent.						
		Show what was solit.						
	The facility Administra	ator was informed of the						
	findings on 5/10/2021							
		5 a.m. during the end of day						
		Administrator was again						
		gs. The Administrator stated						
	he had no questions a	about the findings.						
	No further information	was provided						
	No further information	i was provided.						
	8. For Employee # 24	4, the facility staff failed to						
	ensure a Criminal Ba	•						
	completed at the time	e of hire.						
		.						
	Review of the employ							
	Employee # 24 was n Nurse on 12/31/2019	nired as a Licensed Practical						
	Nuise on 12/31/2019							
	Employee # 24's Crin	ninal Background Check						
		to hire on 12/27/2019 with						
		cumented as "transaction is						
		nere was no documentation						
	-	ntacting the State Police to						
	determine the status	of the search. As of the end						
	of survey, there was r	no final result of the search.						
	0 540/000 + + = =							
		PM, an interview was						
		uman Resources Director						
		e checked and found there						
		s in the personnel file about und Check results being						
		and one of the senter being						

Facility ID: VA0106

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 M APPROVED D. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495135	B. WING				C / 12/2021	
NAME OF PI	ROVIDER OR SUPPLIER		- I	S	TREET ADDRESS, CITY, STATE, ZIP CODE		-	
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 607	"normally the State Peresults to the facility." a mailed copy of a rest At the time of survey, showing that the facilit Employee # 24's crim found in Employee #22 File. On 05/10/2021 at 3:56 conducted with the He who stated she double and found there were Criminal Background finalized. The Humar normally the State Po results to the facility. S mailed copy of a final On 05/10/2021 at 4:30 conducted with the faci informed of the issue. policy on Hiring, Back Files and Termination Administrator stated P the facility's policy. T background checks sh new employees prior The facility policy on P and Reporting, Revise	 a Resources Director stated blice would mail a copy She stated she did not see sult for Employee # 24. no further documentation ty rechecked the status of inal background search was 24's Human Resources (HR) 8 p.m., an interview was uman Resources Director e checked the personnel file no other records about the Check results being a Resources Director stated lice would mail a copy of the She stated she did not see a result for Employee # 24. 0 p.m., an interview was cility Administrator who was A copy of the facility's ground Checks, Personnel s was requested. The would submit a copy of he Administrator stated hould be completed on all to the hire date. Abuse, Neglect, Exploitation ed 11/2016 was reviewed on a 2 of 5 under the topic was the facility's abuse 	F	607				

If continuation sheet Page 27 of 95

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG _		C		
		495135	B. WING			05/	12/2021	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP	•			045 VALLEY VIEW DRIVE IG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 607	3. Not employ or othe who: a. Have been found g exploitation, misappro mistreatment by a cou- b. Have had a finding aide registry concerni- exploitation, misappro c. Have a disciplinary or her professional lic body as a result of ab misappropriation of pr d. Background, refere checks should be corr to or at the time of em administration, in acc state and federal regu- knowledge that an em certification is in quess information to the Adr The Administrator wa During the end of day the facility Administra no documentation of Background check or contacting the State F status of the search. On 5/12/2021 at 11:00	erwise engage individuals guilty of abuse, neglect, opriation of property or urt of law; g entered the State nurse ing abuse, neglect, opriation of property. y action in effect against his sense by a state licensure buse, neglect, exploitation, roperty. ences, and credentials' nducted on employees prior nployment, by facility ordance with applicable ulations . Any person having nployee's license or stion should report such ministrator." s made aware of findings. y debriefing on 5/11/2021, tor was informed there was a final result of the Criminal evidence of the facility staff Police to determine the 5 a.m. during the end of day y Administrator was again gs. The Administrator stated	F	507				
F 609 SS=D	No further informatior Reporting of Alleged	-	F	609				

Facility ID: VA0106

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	-	D HUMAN SERVICES					FORM): 11/05/2021 I APPROVED
STATEMENT O	DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	LETED
		495135	B. WING			_		C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE	00,	12/2021
				20	045 VALLEY VIEW DRIVE			
HERITAGE	E HALL BIG STONE GAP			в	IG STONE GAP, VA 24	4219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	CFR(s): 483.12(c)(1)(4)	F	609				
	- - · · ·	se to allegations of abuse, or mistreatment, the facility						
	involving abuse, negle mistreatment, includir source and misapprop are reported immedia hours after the allegat that cause the allegat serious bodily injury, of the events that cause abuse and do not resu the administrator of th officials (including to t adult protective service for jurisdiction in long- accordance with State procedures.	ng injuries of unknown priation of resident property, tely, but not later than 2 tion is made, if the events ion involve abuse or result in pr not later than 24 hours if the allegation do not involve ult in serious bodily injury, to be facility and to other the State Survey Agency and ses where state law provides term care facilities) in a law through established						
	designated representa accordance with State Survey Agency, withir incident, and if the all appropriate corrective This REQUIREMENT by: Based on staff intervi review, facility docum Protective Service (All to notify Office of Lice	administrator or his or her ative and to other officials in a law, including to the State of 5 working days of the eged violation is verified a action must be taken. is not met as evidenced we and clinical record ent review and Adult PS) report, facility staff failed insure and Certification of ation of property (narcotic of 27 residents in the						

Facility ID: VA0106

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495135	B. WING			C 05/12/2021		
NAME OF PF	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	-		
HERITAGE	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 609	Continued From page	29	F	609				
	diagnoses including h paraplegia, cauda equ back and wrist pain, a the quarterly minimum assessment reference scored 12/15 on the b status and was asses delirium, psychosis, o The Office of Licensu an adult protective se resident's Percocet w for administration on 2 and 6 AM doses. The doses of the medicati	as missing and not available 2/14/2020 for the midnight e report indicated that 52 on were missing. OLC did eported incident concerning d to this resident"s						
	5/10/2021, the reside	terviewed the resident on nt reported always receiving rally having pain under						
F 646 SS=D		ector of nursing during daily ver the course of the survey.	F	646				
	state mental health au disability authority, as significant change in t	t who has mental illness or						

Facility ID: VA0106

If continuation sheet Page 30 of 95

	MENT OF HEALTH AN S FOR MEDICARE & I					FORM	D: 11/05/2021 APPROVED 0. 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_		C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STA	ATE, ZIP CODE		-
HERITAGI	E HALL BIG STONE GAP			045 VALLEY VIEW DRIVE	219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 646	by: Based on resident int clinical record review, the state mental healt significant change in t resident who has mer 27 residents, Residen The findings included For Resident #121, th the resident to the stat for a Level II PASARF expression of suicidal separate suicide atter higher level of care for Resident #121's diagn diagnoses, which incl Mood Disorder due to Condition, Schizoaffe Major Depressive Dis Unspecified, Unspecifie Behavioral Disturband Unspecified Cerebrov B12 Deficiency Anem Diabetes Mellitus with Unspecified. The most recent quar set) with an ARD (ass 4/02/21 assigned the interview for mental s section C, Cognitive F was coded as requirir eating, extensive assi	is not met as evidenced terview, staff interview and facility staff failed to notify h authority following a he mental condition of a natal illness for review for 1 of attal illness resulting in three inpts requiring transfer to a llowing each incident. The attal is a line attal attal incident a limited to ascular Disease, Vitamin ia Unspecified, and Type 2 biabetic Neuropathy terly MDS (minimum data essment reference date) of resident a BIMS (brief tatus) score of 3 out of 15 in Patterns. Resident #121 ag supervision only for stance with bed mobility, giene, and being totally	F 646				

Facility ID: VA0106

If continuation sheet Page 31 of 95

	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
		495135	B. WING					C 12/2021	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE,	ZIP CODE			
	E HALL BIG STONE GAP			20	45 VALLEY VIEW DRIVE				
TENTAG	TALL DIG STONE GAP			Bl	G STONE GAP, VA 24219	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE	
F 646	Continued From page	31	F 6	46					
	observed Resident #1 chair in the common a watching television. S asked the resident ho #121 immediately res resident further stated pray every day that I to pm, surveyor again sp presence of Surveyor this surveyor could low #121 stated "what's w tried to choke myself" (he/she) "turned it loo Resident then becam- were tired of living. A nursing progress no states "this nurse was nursing assistant) wha answer call bell call b and was laying behind neck when asked abc didn't know it was tha A subsequent nursing 2/04/21 9:06 pm state to res about (him/her) had call bell around n didn't want to hurt (hir didn't know it was tha [sp] (he/she) had prev to hurt (himself/herset to er res stated (he/sh	ell was pulled out of the wall d and across res (resident) but this res stated (he/she) t way." I progress note dated es "this nurse went in to talk going to er where (he/she) eck res stated (he/she) nself/herself) that (he/she) t way I explained to res were viously said (he/she) wanted if) that (he/she) needs to go he) didn't even remember wel to say anything just							
	Resident #121 was tra	ansported to the local ER							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVE COMPLETED C		
	495135 OF PROVIDER OR SUPPLIER							
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HERITAGI	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE IG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 646	omitted) Discharge Si states in part, "75-yea in for suspected suicid home reports that the (his/her) nurse call lig (his/her) neck. The p does not remember the remember any intent (He/she) admits to be (he/she) has no intent (himself/herself). In the have acute blood loss kidney injury) with UT (He/she) was admitte one-to-one"; "Crisis w recommended (he/she) omitted) that can com- practitioner), but (facil Today (he/she) was c (facility name omitted) require [sp] COVID 19 being negative (antige Nursing home was no had previously been 0 6th. Because of new patient was transferred Patient is not able to b decisions with (his/he continued suicidal ideations/depression/ Resident #121's Physe from (facility name on in part, "Patient was a (He/she) is still active (He/she) should conti "Patient is now medic	 /21. The (hospital name ummary dated 2/09/21 ar-old (male/female) brought dal intent. The nursing y found (him/her) with ht cord wrapped around atient states that (he/she) his nor does (he/she) to hurt (himself/herself). ing depressed but states tion of harming he ER (he/she) was found to a anemia with AKI (acute I (urinary tract infection). d to the ICU with ras consulted and initially e) go back to (facility name sult psychiatry NP (nurse lity name omitted) declined. oordinate [sp] a bed with) for inpatient psych, but 29 was positive today, after en and 4plex 2/05/21). tified and stated that patient COVID positive status ed to (facility name omitted). make (his/her) own medical r) confused status, dementia". 	F	646				

Facility ID: VA0106

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	D: 11/05/2021 MAPPROVED D: 0938-0391	
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135					(X3) DATE SURVEY COMPLETED C		
		495135	B. WING				12/2021	
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-		
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 646	and will assist in getti omitted) inpatient psy Resident #121 was ac omitted) for inpatient discharged on 2/27/2 Resident #121 was re 2/27/21 following inpa- (facility name omitted A nursing progress no states "this nurse was cna that res roommat had put call bell arour nurse spoke with res was trying to kill herse when it started to hur 9:44 pm states "Upon injuries noted by this transported to the loc. The After Visit Summa omitted) Emergency I states in part, "Follow medicine on an outpa suicidal precautions". Resident #121 was se the following day on 4 states in part, "Per nu suicide attempt by wr (his/her) neck and wa attempt and was retur (facility name omitted memory problem. Su (patient currently cons Discussed with patier	to accept patient in transfer ng patient to (facility name rch as previously planned". dmitted to (facility name psych care on 2/13/21 and 1. eadmitted to the facility on atient psychiatric care at). ote dated 4/11/21 7:46 pm is setting at desk was told by is had told (him/her) that res ind (his/her) neck when this (he/she) stated (he/she) elf but (he/she) stopped t". Addendum dated 4/11/21 in assessment of res o [sp] nurse". Resident #121 was al ER at 7:58 pm. ary from (facility name Department dated 4/11/21 r-up with behavioral itient basis. Maintain een by the psychiatric NP 4/12/21, the progress note irrsing patient had made a apping call bell around is sent out to E.R. r/t suicide rned back to the facility from	F	646				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495135	B. WING					C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		-	
HERITAG	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BI		(X5) COMPLETION DATE
F 646	I'm glad I don't.' Deni harm/suicidal ideation denies anxiety". Rece "continue constant ob Resident #121 was se psychologist via teleh note from the visit sta Resident with progres 7:46 pm, finding Resi around (his/her) neck intent or plan or stren confronted, Resident of doing that""(He/ wanted to die but den requested that with ea person be appointed, for a one on one with attention and support be a suicide gesture v out". Resident #121 was se psychologist on 4/28/ progress note states i session indicated that don't want to live""' started to cry saying ((he/she) did not want expressing is not suic live". Current risk fac was documented as r A nursing progress not states in part "Late no Resident was found in	es thoughts of self is. Endorses depressed; ommendations include iservation". een by the licensed ealth on 4/14/21, progress tes in part, "Approached iss note report of 4/11/21, dent with call bell cord . However, no evidence of gth to tighten cord. When said (he/she) had no recall she) said (he/she) still ied intent or plan""It is ach shift change, a staff who would spend 10 mins. Resident for positive . Incident of 4/11 appears to w/o intent or plan to carry een by the licensed 21 via telehealth and in part, "Staff consult prior to t Resident keeps saying 'I 'at end of session (he/she) he/she) could not do it and to live. Resident has ision (he/she) has no plan th to do it. What Resident is idal ideation but no will to tor for suicidal/self injury	F	646				

Facility ID: VA0106

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STATE MENT OF DEFICIENCIES AND PLAY OF CORRECTION (M) IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: A BUILDING		-	D HUMAN SERVICES				FORM	D: 11/05/2021 APPROVED D. 0938-0391
489135 B. WNG 05/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ANDRESS, CITY, STREE, 2IP CODE 2045 VALLEY VIEW DRVE BIO STONE CAP, VA. 24219 205 VALLEY VIEW DRVE BIO STONE CAP, VA. 24219 000000000000000000000000000000000000	STATEMENT C	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /		(X3) DATE SURVEY COMPLETED		
245 VALLEY VIEW DRIVE BIG STORE CAP. Vol. 22479 PROVIDER CAP, VOL 22479 Image: Trag SUMMARY STATEMENT OF DEFICIENCIES (RACH DEFICIENCY MIST RE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Image: Trag CROSS-REFERENCE OF THE APPROPRIATE DEFICIENCY) COMPLEX (RACH CORRECTIVE ACTION NOULD BE (RACH CORRECTIVE ACTION NOULD BE CROSS-REFERENCE OF THE APPROPRIATE DEFICIENCY) COMPLEX (RACH CORRECTIVE ACTION NOULD BE CROSS-REFERENCE OF THE APPROPRIATE DEFICIENCY) F 646 Resident was turning blue and when released and united call light cord, resident stated (he/she) wished to die and that 1 had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 984. Placed aide 1 on 1 while calling transport and notifying doctor and family'. Subsequent progress note dated 50/1/21 12:39 an states in part "ate note for 2232 (10:32 pm) transport arived As resident was leaving (he/she) stated (he/she) ididn't remember tying call light cord around (his/her) neck and (he/she) didn't Know why (he/she) would do something like that''. The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly Suicidar due to the severity of (his/her) does not nead protective custody at a paych facility to prevent suicide. There is pust no value in this. Please remove the call cord from (his/her) does not need protective custody at a paych facility to prevent suicide. There is just no value in his. Please remove the call cord from (his/her) does not need protective custody at a paych facility to prevent suicide. There is just no value in his. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay". <td></td> <td></td> <td>495135</td> <td>B. WING</td> <td></td> <td>_</td> <td></td> <td></td>			495135	B. WING		_		
HERITAGE HALL BIG STONE GAP BIG STONE GAP, VA 24219 (M4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST ER RECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 000000000000000000000000000000000000	NAME OF PF	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
(M4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST DE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S FLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (His/Sho) ACTION TO THE ATTION SHOULD BE (His/Sho) ACTION THE ATTION SHOULD BE (His/Sho) ACTION THE ATTION SHOULD BE (His/Sho) ACTION THE ACTION SHOULD BE (His/Sho) ACTION THE ACTION SHOULD BE (His/Sho) ACTION THE ACTION SHOULD BE	HERITAGE	HALL BIG STONE GAP						
Imaging Twg IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PRETX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMMENTIFYING INFORMATION) F 646 Continued From page 35 Resident was turning blue and when released and united call light cord, resident stated (he/she) wished to die and that 1 had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 98.4. Placed aide 1 on 1 while calling transport and notifying doctor and family". Subsequent progress note dated 5/01/21 12:39 am states in part "late note for 2232 (10:32 pm) transport arrivedAs resident was leaving (he/she) stated (he/she) idin't remember tying call light cord around (his/her) neck and (he/she) didn't know why (he/she) would do something like that". The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly "suicidal" due to the severity of (his/her) dementia. ((He/she) can't really decide to commit suicide)And (he/she) is so disabled (bed bound) that (he/she) is not able to act on a suicidal impulse even if (he/she) idid have one. There is no known treatment for (his/her) acting out and having another psych evaluation and treatment would not do (him/her) any good. (He/she) does not need protective custody at a psych facility to prevent suicide. There is just nov value in this. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay". DON (director of nursing) stated the facility does not have a policy					-			
Resident was turning blue and when released and untied call light cord, resident stated (he/she) wished to die and that I had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 98.4. Placed aide 1 on 1 while calling transport and notifying doctor and family". Subsequent progress note dated 5/01/21 12:39 am states in part "late note for 2232 (10:32 pm) transport arrivedAs resident was leaving (he/she) stated (he/she) didn't remember tying call light cord around (his/her) neck and (he/she) didn't know why (he/she) would do something like that". The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly 'suicidal' due to the severity of (his/her) demetia. ((He/she) can't really decide to commit suicide). And (he/she) is so disabled (bed bound) that (he/she) is not atble to act on a suicidal impulse even if (he/she) did have one. There is no known treatment for (his/her) acting out and having another psych evaluation and treatment would not do (him/her) any good. (He/she) does not need protective custody at a psych facility to prevent suicide. There is just no value in this. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay".	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORREC CROSS-REFEREN	CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA		(X5) COMPLETION DATE
and untied call light cord, resident stated (he/she) wished to die and that I had not found (him/her) so soon. Vitals were taken B/P 118/76, Pulse 84, O2 96, Resp 18, Temp 98.4. Placed aide 1 on 1 while calling transport and notifying doctor and family". Subsequent progress note dated 5/01/21 12:39 am states in part "late note for 2232 (10:32 pm) transport arrivedAs resident was leaving (he/she) stated (he/she) din't remember tying call light cord around (his/her) neck and (he/she) didn't know why (he/she) would do something like that". The After Visit Summary from (facility name omitted) Emergency Department dated 4/30/21 states in part, "Patient is not truly 'suicidal' due to the severity of (his/her) dementia. ((He/she) can't really decide to commit suicide). And (he/she) is so disabled (bed bound) that (he/she) is not able to act on a suicidal impulse even if (he/she) did have one. There is no known treatment for ((his/her) adomt ing another psych evaluation and treatment would not do (him/her) any good. (He/she) does not need protective custody at a psych facility to prevent suicide. There is just no value in this. Please remove the call cord from (his/her) reach. (Facility name omitted) is a safe and good place for (him/her) to stay". On 5/06/21 at 12:33 pm, the DON (director of nursing) stated the facility does not have a policy	F 646			F 646				
addressing what triggers a PASARR to be done. The administrator provided with surveyor with Resident #121's Level I PASARR dated 10/12/18, which stated the resident met nursing facility		Resident was turning and untied call light co wished to die and that so soon. Vitals were O2 96, Resp 18, Tem while calling transport family". Subsequent 12:39 am states in pa pm) transport arrived (he/she) stated (he/sh call light cord around didn't know why (he/s that". The After Visit Summa omitted) Emergency I states in part, "Patien the severity of (his/he really decide to comm so disabled (bed bour to act on a suicidal im have one. There is no (his/her) acting out an evaluation and treatm any good. (He/she) d custody at a psych fac There is just no value call cord from (his/her omitted) is a safe and stay". On 5/06/21 at 12:33 p nursing) stated the fac addressing what trigg The administrator pro Resident #121's Leve	blue and when released ord, resident stated (he/she) t I had not found (him/her) taken B/P 118/76, Pulse 84, p 98.4. Placed aide 1 on 1 and notifying doctor and progress note dated 5/01/21 rt "late note for 2232 (10:32 As resident was leaving he) didn't remember tying (his/her) neck and (he/she) he) would do something like ary from (facility name Department dated 4/30/21 t is not truly 'suicidal' due to r) dementia. ((He/she) can't hit suicide). And (he/she) is nd) that (he/she) is not able pulse even if (he/she) did to known treatment for ad having another psych ent would not do (him/her) loes not need protective cility to prevent suicide. in this. Please remove the t) reach. (Facility name good place for (him/her) to to m, the DON (director of cility does not have a policy ers a PASARR to be done.					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	
		495135	B. WING				
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGE	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE IG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 646	Continued From page	36	F	646			
F 689 SS=G	administrator, assista nurse consultant #1, n VP of Operations of F referred for a Level II following three separa Surveyor spoke with t on 5/12/21 at 10:45 a did not know why the for a Level II PASARF referred. Administrate social worker is brand some things out". A progress note dated part, "SSD left a mess (him/her) back, so (he PASARR for the res a No further information presented to the survice conference on 5/12/2 Free of Accident Haza CFR(s): 483.25(d)(1)(1) §483.25(d)(2)Each re- supervision and assis accidents. This REQUIREMENT by:	ate suicide attempts. the administrator and DON m, administrator stated they resident was not referred R but (he/she) has now been or further stated that the d new and they are "ironing d 5/11/21 6:02 pm states in sage with Ascend to call a/she) can schedule a at this time". n regarding this issue was ey team prior to the exit 1. ards/Supervision/Devices (2)	F	589			
	by:	terview, staff interview,					

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES				FORM	D: 11/05/2021 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_	(05/	C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 2			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	clinical record review, complaint investigatio ensure the resident en- free of accident hazar availability for 1 of 27 and failed to include in elopement with identifi able to exit the buildin current residents (Res The findings included 1. For Resident #121 remove the resident's three separate incident the call light cord wrap incidents resulted in the care following incident 4/11/21. In the 5/1/21 found in room laying i call light tied tightly ar was turning blue and call light cord, resident die. This is harm. Resident #121's diagn diagnoses, which incl Mood Disorder due to Condition, Schizoaffe Major Depressive Dis Unspecified, Unspecifi Behavioral Disturband Unspecified, Cerebrov B12 Deficiency Anem Diabetes Mellitus with Unspecified. The most recent quar	and during the course of a n, facility staff failed to nvironment remained as ds related to call light cord residents, Resident #121 nvestigation of an fying how the resident was of for one (1) of 27 sampled sident #64). , the facility staff failed to call light cord following nts in which the resident had oped around their neck. Two ransfer to a higher level of ts occurring on 2/04/21 and attempt, the resident was n bed with eyes closed with ound neck. The resident when released and untied at stated (he/she) wished to hosis list indicated uded, but not limited to be Known Physiological ctive Disorder Unspecified, order Recurrent fied Dementia with ce, Dysphagia following rascular Disease, Vitamin ia Unspecified, and Type 2	F 689				

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	-	D HUMAN SERVICES					FORM	D: 11/05/2021
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	LETED
		495135	B. WING			_		C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	interview for mental s section C, Cognitive F was coded as requirin eating, extensive assid dressing, personal hy dependent in transfer On 5/04/21 at approxi- observed Resident #1 chair in the common a watching television. S asked the resident ho #121 immediately res- resident further stated pray every day that I w hand-held looped stra- within reach, surveyor for and resident stated need them". On 5/04. again spoke with the Surveyor #2 and aske surveyor could look a stated "what's wrong of choke myself" and res- (he/she) "turned it loo Resident then becam- were tired of living. A nursing progress no states "this nurse was nursing assistant) wha and was laying behind neck when asked abo didn't know it was that A subsequent nursing	resident a BIMS (brief tatus) score of 3 out of 15 in Patterns. Resident #121 og supervision only for stance with bed mobility, giene, and being totally s. imately 2:45 pm surveyor 21 sitting up in a reclining area with other residents Surveyor introduced self and w they were doing, Resident ponded "depressed". The d "I'd rather be dead" and "I will die". The resident had a up with jingle bells attached r asked what the bells were d "to get the nurses when I /21 at 6:34 pm, surveyor resident in the presence of ed the resident if this t their neck. Resident #121 with my neck, oh I tried to sident further stated se when it started to hurt". e tearful and stated they the dated 2/04/21 8:48 pm is notified by cna (certified en (he/she) went in to ell was pulled out of the wall d and across res (resident) but this res stated (he/she) t way."	F	689				

Facility ID: VA0106

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						10. 0938-039		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	TE SURVEY MPLETED		
	495135 F PROVIDER OR SUPPLIER					С		
		495135	B. WING		0	5/12/2021		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL				
				2045 VALLEY VIEW DRIVE				
HERITAG	E HALL BIG STONE GAF			BIG STONE GAP, VA 24219				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE		
F 689	Continued From page	e 39	F 6	89				
) going to er where (he/she)						
		neck res stated (he/she)						
		mself/herself) that (he/she)						
didn't know it was that way I explained to res were								
	[sp] (he/she) had previously said (he/she) wanted							
		elf) that (he/she) needs to go						
		he) didn't even remember						
	because I say it does	bel to say anything just						
	because I say it does							
	Resident #121 was tr	ansported to the local ER						
		/21. The (hospital name						
	omitted) Discharge S	ummary dated 2/09/21						
		ar-old (male/female) brought						
	-	idal intent. The nursing						
		ey found (him/her) with ght cord wrapped around						
	, , ,	patient states that (he/she)						
		his nor does (he/she)						
		to hurt (himself/herself).						
		eing depressed but states						
	(he/she) has no inten	-						
		the ER (he/she) was found to						
		s anemia with AKI (acute						
	(He/she) was admitte	ΓI (urinary tract infection).						
	, ,	vas consulted and initially						
		ne) go back to (facility name						
		sult psychiatry NP (nurse						
	practitioner), but (faci	ility name omitted) declined.						
		coordinate [sp] a bed with						
		l) for inpatient psych, but						
		9 was positive today, after						
		en and 4plex 2/05/21). otified and stated that patient						
		COVID positive November						
		COVID positive status						
		ed to (facility name omitted).						
	Patient is not able to							

Facility ID: VA0106

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021
STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE	D. 0938-0391 SURVEY LETED
		495135	B. WING					C 12/2021
NAME OF PF	OVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CO	DE	-	
HERITAGE	HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 689	from (facility name on in part, "Patient was a (He/she) is still activel (He/she) is still activel (He/she) should contii "Patient is now medic have discussed with h omitted) who agrees t and will assist in gettin omitted) inpatient psy Resident #121 was ac omitted) for inpatient p discharged on 2/27/27 resident's clinical records Resident #121 was re 2/27/21 following inpat (facility name omitted) A nursing progress no states "this nurse was cna that res roommatch had put call bell arour nurse spoke with res when it started to hurt 9:44 pm states "Upon injuries noted by this it transported to the local The After Visit Summatch	r) confused status, dementia". dementia". dician Discharge Summary hitted) dated 2/11/21 states also seen by psychiatry. by suicidal/homicidal. nue full psych precautions"; ally stable for discharge. I hospitalist at (facility name to accept patient in transfer ing patient to (facility name ch as previously planned". dmitted to (facility name psych care on 2/13/21 and 1. Surveyor requested the ords on 5/10/21, however, as a had not been received. eadmitted to the facility on titent psychiatric care at). bute dated 4/11/21 7:46 pm is setting at desk was told by the had told (him/her) that ress hd (his/her) neck when this (he/she) stated (he/she) elf but (he/she) stopped ". Addendum dated 4/11/21 assessment of res o [sp] nurse". Resident #121 was al ER at 7:58 pm. ary from (facility name Department dated 4/11/21	F	689				

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM): 11/05/2021 1 APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		STRUCTION		(X3) DATE COMP	LETED
		495135	B. WING				(05/'	C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STAT	E, ZIP CODE		
				2045 VA	ALLEY VIEW DRIVE			
HERITAGI	E HALL BIG STONE GAP			BIG ST	TONE GAP, VA 242	19		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 689	medicine on an outpa suicidal precautions". resident's clinical recc omitted) emergency of however, as of 5/18/2 received. A nursing progress not states "res back from only order is verbal or up with (name omitted eyes closed". Resident #121 was se (nurse practitioner) th the progress note stat patient had made a se call bell around (his/h E.R. r/t suicide attemp the facility from (facilit diagnosis of memory in bed (patient curren CNA). Discussed witt suicide yesterday. Pt remember that, I'm gli of self harm/suicidal id depressed; denies an include "continue con Resident #121 was se psychologist via teleh note from the visit sta Resident with progres 7:46 pm, finding Resid around (his/her) neck intent or plan or stren confronted, Resident of doing that""(He/	tient basis. Maintain Surveyor requested the ords from (facility name lepartment on 5/05/21, 1 the records had not been be dated 4/11/21 11:58 pm (facility name omitted) er der from hospital to follow d) on 4/12/21 res in bed with een by the psychiatric NP e following day on 4/12/21, tes in part, "Per nursing uicide attempt by wrapping er) neck and was sent out to ot and was returned back to ty name omitted) with a problem. Subjective: Lying tly constant observation by h patient (his/her) attempt at verbalized, 'I don't ad I don't.' Denies thoughts deations. Endorses xiety". Recommendations stant observation".	F 68	39				

Facility ID: VA0106

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CENTER	S FOR MEDICARE &	ID HUMAN SERVICES MEDICAID SERVICES				FORM OMB NC	0: 11/05/2021 1 APPROVED 0. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION			LETED
		495135	B. WING		_		_ 12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST			
HERITAG	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	person be appointed, for a one on one with attention and support be a suicide gesture v out". Resident #121 was se psychologist on 4/28/ progress note states i session indicated that don't want to live" ' started to cry saying ((he/she) did not want expressed in prior ses and no way or strengt expressing is not suic live". Current risk fac was documented as r On 5/06/21 at 6:58 ar (licensed practical nut Resident #121 on 2/0 aforementioned incide LPN #1 stated that in the resident with the of their neck and original wanted to hurt (himse (he/she) did not say the second time (he/she) around (his/her) neck and the CNA came ar the resident had alrea said it started to hurt a Surveyor asked LPN time to prevent it from #1 responded CNAs of	ach shift change, a staff who would spend 10 mins. Resident for positive . Incident of 4/11 appears to w/o intent or plan to carry een by the licensed 21 via telehealth and in part, "Staff consult prior to t Resident keeps saying 'I "at end of session (he/she) (he/she) could not do it and to live. Resident has ssion (he/she) has no plan th to do it. What Resident is cidal ideation but no will to tor for suicidal/self injury none. m, surveyor spoke with LPN rse) #1 who was caring for 4/21 and 4/11/21 during the ents with the call bell cord. February, the CNA found call light cord looped around illy the resident said (he/she) eff/herself) but then said hat. LPN #1 stated that the	F 689				

Facility ID: VA0106

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	-	(X3) DATE COMP	SURVEY LETED
		495135	B. WING			(05/	C 12/2021
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
HERITAGE	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE	E		
				BIG STONE GAP, VA 2	4219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	states in part "Late no Resident was found in eyes closed with call I Resident was turning and untied call light or wished to die and that so soon. Vitals were O2 96, Resp 18, Tem while calling transport family". Subsequent 12:39 am states in par pm) transport arrived (he/she) stated (he/sh call light cord around didn't know why (he/s that". The After Visit Summa omitted) Emergency I states in part, "Patien the severity of (his/he really decide to comm so disabled (bed bour to act on a suicidal im have one. There is no (his/her) acting out an evaluation and treatm any good. (He/she) d custody at a psych fac There is just no value call cord from (his/her omitted) is a safe and stay". Surveyor reque records from (facility r department on 5/05/2 the records had not b	be dated 5/01/21 12:33 am be for 2158 (9:58 pm): in room laying in bed with light tied tightly around neck. blue and when released ord, resident stated (he/she) t I had not found (him/her) taken B/P 118/76, Pulse 84, p 98.4. Placed aide 1 on 1 and notifying doctor and progress note dated 5/01/21 rt "late note for 2232 (10:32 As resident was leaving he) didn't remember tying (his/her) neck and (he/she) he) would do something like ary from (facility name Department dated 4/30/21 t is not truly 'suicidal' due to r) dementia. ((He/she) can't hit suicide). And (he/she) is nd) that (he/she) is not able pulse even if (he/she) did to known treatment for id having another psych- nent would not do (him/her) loes not need protective cility to prevent suicide. in this. Please remove the -) reach. (Facility name good place for (him/her) to ested the resident's clinical name omitted) emergency 1, however, as of 5/18/21 een received.	F 68		DEFICIENCY)		
	Nursing progress note	e dated 5/01/21 9:11 am					

Facility ID: VA0106

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		D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING			_		C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE VIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	states in part "Reside with no new orders no suicidal ideations at the observation and giver needing assistance. Ib bell and Resident stat understand how to us On 5/10/21 at 1:54 pm #3 who was Resident RN #3 stated Resider and they went to answ with the call light cord neck 2 to 3 times and it. RN #3 stated the re "reddish bruise place" in their neck and neck a rubber band on you call light cord became and caused the light t that "after the fact I was before". Resident #121's curre problem area stating is suicidal ideations", ca in part, "monitor safet monitoring/sitter with "hand call bell", "In ro On 5/05/21 at approxi spoke with the MDS r the manager on Satur the resident the hand to the care plan. On 5/04/21 at approxi	nt back from ER for EVAL bted. Resident denies his time. Placed on 1:1 h hand bell to ring when Educated on use of hand tes 'I'm not too far gone to e a bell'". n, surveyor spoke with RN #121's nurse on 4/30/21. ht #121's call light was on ver it and found resident wrapped around (his/her) had to get help to remove esident's neck had a ' where the call light clip was a papeared "like if you wear r wrist". RN #3 stated the e unplugged from the wall o come on. RN #3 stated as told (he/she) had done it ent care plan includes the in part "has hx (history) of re plan approaches include y needs, 1 on 1 res during times of crisis", om visits 2x day by staff". imately 3:30 pm, surveyor hurse who stated they were rday, 5/01/21, and they gave bells that day and added it	F	689				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· <i>`</i>		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING			_		C 12/2021
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HERITAGE	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	electrical cord plugges side of the bed approximattress. If the reside electrical cord and our reach. Surveyor did r the bed on 5/04/21 du survey. Both call lig the call light port on th on the other empty be The resident's over be attached to turn the lig Surveyor #2 discusses with the administrator DON (director of nurs #1. The following morning approximately 8:00 ar resident's room and o staff member in the ro stated they were mov removing the call light resident was suicidal the cords out. Reside during this time. At 11 the resident's room ar left side of the bed ha plate covering it and to into an outlet to the rig headboard with a cord cord going down the v were removed and the covered with a solid p the over bed light had On 5/06/21 at 1:50 pm	hast the wall with the bed's d into an outlet on the left kimately two feet above the ent were in the bed, the tlet would be within arm's not observe the resident in uring the first day of the ht cords were plugged into ne wall and cords were lying ed in the resident's room. ed light had a string ght on and off. At 6:55 pm d the room observations , assistant administrator, ing), and nurse consultant g, on 5/05/21 at m, surveyor entered the bserved a maintenance born. Maintenance worker ing the bed outlet and t from the room because the and they needed to get all ent #121 was not in the room :06 pm, surveyor observed nd noted the outlet on the d been replaced with a solid he bed was now plugged ght side of the bed's d cover covering over the wall. The call light cords e call light plug in ports were late. The string attached to	F	689	9			
	the over bed light had On 5/06/21 at 1:50 pn administrator, DON, a	been removed. n, surveyor spoke with the						

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D: 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING			_		C 12/2021
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, S	TATE, ZIP CODE		
HERITAGE	HALL BIG STONE GAP	1			045 VALLEY VIEW DRIVE			
					-			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689		e call bell cord. The DON	F	689				
		e no recommendations from						
) for suicide precautions						
	when Resident #121 v	rator stated after the second						
	•	was sent to the ER and the						
	ER decided that (he/s	she) did not need evaluation						
	and the facility put (hi							
	· · /	was seen by (name omitted) her and (name omitted)						
		administrator stated the one						
		ontinued until the nurse						
	practitioner and psych							
		ninistrator further stated that						
	-	e/she) was sent to the ER Il bell cord was taken away.						
		ted that yesterday they took						
		ank cover and wire molded						
		ord to the wall and removed						
	with batteries.	dent's radio and replaced it						
	with batteries.							
	On 5/10/21 at 1:45 pn	n, surveyor spoke with the						
	administrator and DO	N and asked why Resident						
	-	was not removed prior to the						
		ON stated that following the s "something that was						
		see it based on what the ER						
	was saying".							
	Surveyor requested a	nd received the facility						
	policy and procedure							
	Precautions" which st							
	Policy							
		uires closer observation						
	because of possible s b. Depressed reside							
	e. Confused reside							
		ory of previous suicide						

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495135	B. WING				U /12/2021
NAME OF P	ROVIDER OR SUPPLIER			ŝ	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	From a nursing stand be kept in mind when organic brain syndrom any talk of death, use (regardless of how mi and must be reported resident's chart. Procedures 2. Maintain safe envi objects, cleaning solu 3. Careful documenta assessment in Clinica On 5/12/21 at 12:30 p administrator, DON, r nurse consultant #2 s concern of Resident # being removed follow of the resident wrappi their neck. No further information presented to the surv conference on 5/12/2 This is a complaint de 2. The facility's respon elopement failed to in investigation into how exit the building without Resident #64's minima assessment, with an a (ARD) of 3/1/21, had being able to make set able to understand ot	expressed a wish to die point, suicide must always caring for the resident with ne. Any attempt at suicide, lessness of life or attempts inor), are considered serious and written on the ronment by removing sharp tions etc. ation of subjective/objective al Record. om during a meeting with the nurse consultant #1, and urveyor discussed the #121's call bell cord not ing two separate incidents ing the call light cord around n regarding this issue was ey team prior to the exit 1. eficiency. onse to Resident #64's clude documentation of an othe resident was able to out facility staff being aware.	F	689			

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		495135	B. WING			C 05/12/2021		
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 689	score was documente Resident #64 was doo limited assistance wit toilet use, and person was diagnosed with the Resident #64's clinica nursing note dated 4/ appeared to be a late p.m. This note includ "A nurse from North S asked if I had all my p checked on all my pa and accounted for wit (patient). The nurse s service name omitted and jacket walking do (hospital) thought (the here (at) this facility. road together picked church name omitted to this facility no acute Documentation indica immediately placed o and was also placed o On 5/11/21 at 10:22 a Administrator, Directo Nurse Consultant #2 availability of recordin cameras. It was repor have security camera On 5/11/21 at 4:25 p. Maintenance Director about the facility's door reported that all doors the exception of the facility	ed as six (6) out of 15. cumented as requiring h bed mobility, transfers, ial hygiene. Resident #64 raumatic brain injury (TBI). Al documentation included a 24/21 at 12:55 a.m. that entry for 4/23/21 at 10:45 ed the following information: Side Hall called this nurse batients on the floor, 1 tients everyone was present th the exception of this stated (local ambulance) seen a male wearing a hat with the hill past the e patient) might be a patient Two nurses drove down the (patient) up (at) (local) (patient) transported back e distress noted." ated Resident #64 was in a secure unit in the facility on 'every 15 minute' checks. a.m., the facility's or of Nursing (DON), and was asked about the tags from facility security orted the facility does not s. m., the facility's Acting (AMD) was interviewed	F	689				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/05/2021 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_	05/ [,]	C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	IATE, ZIP CODE		
			2	045 VALLEY VIEW DRIVE	<u>:</u>		
HERITAG	E HALL BIG STONE GAP		В	IG STONE GAP, VA 24	4219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 689	there was a door, price front doors, that when someone turned the a On 5/12/21 at 11:13, if provided the survey to written statements ob Resident #64's aforer information was provi- doors were checked a evaluate the function survey team was prov- showed the routine do on 4/23/21 and 4/26/2 not include the times were checked. No ev- system was document investigation into this The written statements working at the time Re 4/23/21 addressed the missing and the return written statements did investigation into how exit the building witho The facility policy title Elopement" (with a re- included the following will identify residents wandering and strive maintaining the least residents." This policy specific prevention of elopement; this policy	The AMD explained that or to residents accessing the a triggered would sound until alarm off. the Assistant Administrator eam with staff members' tained in response to mentioned elopement. No ded to indicate the facility's after the elopement to ng of the door alarms. The vided documentation that bor checks were completed 21; this documentation did of when the facility's doors valuation of the door alarm ted as part of the event. ts provided by facility staff esident #64 eloped on e discovery of the resident n of the resident. The d not address an r Resident #64 was able to out staff being aware. d "Wandering and vision date of March 2019) information: "The facility who are at risk of unsafe to prevent harm while restrictive environment for y focused on the resident and response to an y did not address the y factors that could have	F 689				

Facility ID: VA0106

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	-	ID HUMAN SERVICES				FORM	APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		495135	B. WING			C 05/12/2021		
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGE	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	Continued From page	≥ 50	F	689)			
	document) included th - "The Incident and Ad for all unexplained bru accidents or incidents allegations of theft an residents, visitors or f altercations and asso - "Incident is defined a consistent with the roo that does not result in damage." - "An investigation mu and the incident must	" (no date was found on this ne following information: ccident Report is completed uises or abrasions, all s where there is injury, d abuse registered by amily members and resident						
F 692 SS=D	Administrator, Director Consultant #1, and Ni 5/12/21 at 12:27 p.m. failure of facility staff's to attempt to address to exit the building with was discussed. No a to this issue was prov Nutrition/Hydration St CFR(s): 483.25(g)(1)- §483.25(g) Assisted r (Includes naso-gastric both percutaneous er percutaneous endosc enteral fluids). Based	urse Consultant #2, on During this meeting, the s investigation, of this event, how the resident was able thout facility staff knowledge dditional information related rided to the survey team. tatus Maintenance -(3) nutrition and hydration. c and gastrostomy tubes, ndoscopic gastrostomy and copic jejunostomy, and d on a resident's ssment, the facility must	F	692	2			

Facility ID: VA0106

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		ID HUMAN SERVICES				FORM	MAPPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495135	B. WING _				C 1 2/2021
NAME OF P	ROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>,</u>	
HERITAG	E HALL BIG STONE GAP	•			045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 692	Continued From page	9 51	F	692			
	of nutritional status, s desirable body weigh balance, unless the re demonstrates that this preferences indicate of §483.25(g)(2) Is offer maintain proper hydra §483.25(g)(3) Is offer there is a nutritional p provider orders a ther This REQUIREMENT by: Based on interviews documents, it was de failed to provide servi desirable body weigh sampled current reside The findings include: The facility staff failed recommendations to a weight loss. Resident #44's minima assessment, with an (ARD) of 2/11/21, was 2/12/21. Resident #4 able to make self und to understand others. interview for mental s score was documents Resident #44 was do	ed sufficient fluid intake to ation and health; ed a therapeutic diet when problem and the health care rapeutic diet. is not met as evidenced and the review of termined the facility staff ces to address maintaining trange for one (1) of 27 dents (Resident #44). d to act upon dietary address Resident #44's num data set (MDS) assessment reference date s signed as completed on 4 was assessed as being lerstood and as being able Resident #44's brief tatus (BIMS) summary ed as zero (0) out of 15. cumented as requiring nobility, dressing, toilet use,					

Facility ID: VA0106

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	-	D HUMAN SERVICES				FORM	M APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						(X3) DATE COMF	SURVEY PLETED	
		495135	B. WING			C 05/12/20		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 692	documented as havin eating, transfers, and diagnoses included, to blood pressure, Alzhe and lower back pain. Review of Resident # revealed the following - 116 pounds on 6/2/2 - 120 pounds on 7/1/2 - 121 pounds on 9/2/2 - 101 pounds on 9/2/2 - 101 pounds on 10/1 - 98 pounds on 12/3/2 - 91 pounds on 1/4/2' - 92 pounds on 2/3/2' - 90 pounds on 3/3/2' - 91 pounds on 4/1/2' - 92 pounds on 5/3/2' The following informat notes: - On 10/7/20 at 12:57 revealing a significant and 90 (days) and 13 resident) is (status por resident) receives put (approximately) 50% addition of MedPass May want to consider remeron [sic] in attern follow." - On 12/31/20 at 2:15 12/3; 30 day (weight) (weight): 120 (pounds 116 (pounds) (on) 6/2 (times) 90 and 180 day	g total dependence for bathing. Resident #44's out were not limited to: high simer's disease, depression, 44's clinical documentation g weights: 20; 20; 20; 20; 20; 20; 20; 20; 20; 20;	F	692	2			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION 495135 (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 495135 B. WING 05/12/2021 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 05/12/2021 HERITAGE HALL BIG STONE GAP STREET ADDRESS, CITY, STATE, ZIP CODE 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED D. 0938-0391
495135 B. WHG 05/12/2021 NAME OF PROVIDER OR BUPFLER STREET ADDRESS, CITY, STRE, ZP CODE 2045 WALLEY VIEW DRIVE BIG STONE CAP, VA 2219 2045 WALLEY VIEW DRIVE BIG STONE CAP, VA 2219 00111 (M) ID PIETIX INC SUMMARY STREMENT OF DEFICIENCIES (ESCIDENTIFYING INFORMATION) PROVIDER SA. MOT CONDICTION (ESCIDENTIFYING INFORMATION) PROVIDER SA. MOT CONDICTION (ESCIDENTIFYING INFORMATION) PROVIDER SA. MOT CONDICTION (ESCIDENTIFYING INFORMATION) PROVIDER SA. MOT CONDUCTION (ESCIDENTIFYING INFORMATION) PROVIDER SA. MOT CONDUCTION (Inter Sa. MOT CONDUCTION) PROVIDER SA. MOT CONDUCTION (Inter Sa. MOT CONDUCTION (INTER SA. MOT CONDUCTION) PROVIDER SA. MOT CONDUCTION (Inter Sa. MOT CONDUCTION (INTER SA. MOT CONDUCTION) PROVIDER SA. MOT CONDUCTION (Inter Sa. MOT CONDUCTION (INTER SA. MOT CONDUCTION (INTER SA. MOT CONDUCTION) PROVIDER SA. MOT CONDUCTION (Weight): 101 (NOUTON) </td <td>STATEMENT O</td> <td>OF DEFICIENCIES</td> <td>(X1) PROVIDER/SUPPLIER/CLIA</td> <td>. ,</td> <td></td> <td>-</td> <td>(X3) DATE COMP</td> <td>SURVEY LETED</td>	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	. ,		-	(X3) DATE COMP	SURVEY LETED
HERITAGE HALL BIG STONE GAP 245 VALLEY VIEW DRIVE BIG STONE GAP, VA. 24219 Image: Continued From page 53 PROVIDER'S PLAN OF CORRECTION REGULTORY OR LSC DENTIFYING INFORMATION Image: Continued From page 53 F 692 F 692 Continued From page 53 F 692 Mintazapine. Will recommend Medpass 60 ml (three times a day) for additional calories to support weight gain. Will continue to monitor. - On 1/28/21 at 9:39 am**91 (pounds) (on) 1/4; 30 day (weight): 98 (pounds) (on) 10/1; 180 day (weight): 120 (pounds) (on) 10/1; 180 day (weight): 120 (pounds) (on) 10/1; 180 day (weight): 30, 90 and 180 days. (The resident) is on a regular purce diet. (Oral) intake 7 day (average): (breakfast) - 67% (lunch) - 57% (dinner) - 67%Will recommend start Medpass 120 ml (three times a day) and Prostat 30 ml (twies day). 201 gouphements, 2014) (190 day (weight): not (avaitable); 180 day (weight): 121 (pounds) (on) 30.30 ad at 80 days. (The resident) is on a regular purce diet. (Oral) intake 7 day (average): (breakfast) - 64% (lunch) - 68% (dinner) - 67%. Will recommend start Medpass 120 ml (three times a day) and Prostat 30 ml (twies) 180 days. Will recommend start Medpass 120 ml (three times a day) and prostat 30 ml (twies) 180 days. (The resident) is on a regular purce diet With os support weight gain. Will continue to monitor. - On 3/31/21 at 1-10 P.M**90 (pounds) (on) 3/3 indicating a significant (mes) 90 and 180 days. (The resident) is on a regular purce diet. Will recommend start Medpass 120 ml (three times a day). Will monitor. The following information was found as part of a medical provider note dated 10/1/4/2020: **********************************			495135	B. WING		_		
HERRITAGE HALL BIG STONE GAP BIG STONE GAP, VA 24219 (M) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST ERECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PREFIX (EACH DEFICIENCY WIST ERECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PREFIX (EACH DERECTION (EACH DERECTION DEFICIENCY UST ERECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 00% F 692 Continued From page 53 (Mitazapine. Will recommend Medpass 60 ml (three times a day) for additional calories to support weight gain. Will continue to monitor. - On 1282/21 at 9.39 a.m* 91 (pounds) (on) 114; 30 day (weight): 101 (pounds) (on) 101; 180 day (weight): 101 (pounds) (on) 104; 90 day (weight): 101 (pounds) (on) 144; 90 (pounds) (on) 303 indicating a significant weight loss (itmes) 90 and 180 days. (The resident) is on a regular purce diet. Will recommend Medpass 120 ml (three times a day). Will monitor. <	NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
PREFIX TXG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TXG (EACH ORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLET TXG F 692 Continued From page 53 F 692 Mirtazapine. Will recommend Medpass 60 ml (three times a day) for additional calories to support weight gain. Will continue to monitor. - On 1/28/21 at 9:39 a.m*" 91 (pounds) (on) 10/4; 30 day (weight): 80 (pounds) (on) 10/1; 180 day (weight): 101 (pounds) (on) 10/1; 180 day (weight): 120 (pounds) (on) 10/1; 133, 04ay (weight): 91 (pounds) (on) 10/2; 33, 04ay (weight): 91 (pounds) (on) 10/2; 126, 30 day (weight): 91 (pounds) (on) 10/2; 33, 04ay (weight): 91 (pounds) (on) 10/2; 33, 04ay (weight): 91 (pounds) (on) 10/2; 33 day (weight): 91 (pounds) (on) 10/2; 10/2 (pounds) (on) 10/2 (pounds) (on) 10/2; 10/2 (pounds) (on) 10/2 (pounds) (on)	HERITAGE	E HALL BIG STONE GAP						
Mirtazapine. Will recommend Medpass 60 ml (three times a day) for additional calories to support weight gain. Will continue to monitor. - On 1/28/21 at 9:39 a.m* 91 (pounds) (on) 1/4; 30 day (weight): 98 (pounds) (on) 12/3; 90 day (weight): 120 (pounds) (on) 11/3; 180 day (weight): 120 (pounds) (on) 71/1. Weight loss is significant (times) 30, 90 and 180 days. (The resident) is on a regular purce diet. (Oral) intake 7 day (average): (breakfast) - 67% (lunch) - 57% (dinner) - 67% Will recommend start Medpass 120 ml (three times a day) and Prostat 30 ml (twice a day). Will monitor for additional needs." - On 2/25/21 at 6:53 a.m*92 (pounds) (on) 2/3; 30 day (weight): 91 (pounds) (on) 11/4; 90 day (weight): not (available); 180 day (weight): 121 (pounds) (on) 8/3. Weight loss is significant (times) 180 days. BMI (body mass index): 15.8 indicating underweight status. (The resident) is on a regular purce diet with no supplements. (Oral) intake 7 day (average): (breakfast) - 64% (lunch) - 68% (dinner) - 67%. Will recommend start Medpass 120 ml (three times a day) to support weight gain. Will continue to monitor. - On 3/31/21 at 4:10 P.M*90 (pounds) (on) 3/3 indicating a significant weight loss (times) 90 and 180 days. (The resident) is on a regular purce diet. Will recommend Medpass 120 ml (three times a day). Will monitor. - On 3/31/21 at 4:10 P.M*90 (pounds) (on) 3/3 indicating a significant weight loss (times) 90 and 180 days. (The resident) is on a regular purce diet. Will recommend Medpass 120 ml (three times a day). Will monitor. The following information was found as part of a medical provider note dated 10/14/2020: "Today we will start giving (the resident) 90cc of	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRE CROSS-REFERE	CTIVE ACTION SHOULD BI		COMPLETION
Resident #44's clinical documentation failed to show evidence of addressing the aforementioned	F 692	Mirtazapine. Will reco (three times a day) fo support weight gain. A - On 1/28/21 at 9:39 a 1/4; 30 day (weight): 9 day (weight): 101 (po (weight): 120 (pounds significant (times) 30, resident) is on a regula 7 day (average): (brea (dinner) - 67% Will 120 ml (three times a (twice a day). Will mo - On 2/25/21 at 6:53 a 2/3; 30 day (weight): 9 (weight): not (availabl (pounds) (on) 8/3. We (times) 180 days. BM indicating underweigh a regular puree diet w intake 7 day (average - 68% (dinner) - 67% Medpass 120 ml (three weight gain. Will cont - On 3/31/21 at 4:10 F 3/3 indicating a signifi and 180 days. (The re puree diet. Will recom (three times a day). W	ommend Medpass 60 ml r additional calories to Will continue to monitor. a.m " 91 (pounds) (on) 98 (pounds) (on) 12/3; 90 unds) (on) 10/1; 180 day s) (on) 7/1. Weight loss is 90 and 180 days. (The lar puree diet. (Oral) intake akfast) - 67% (lunch) - 57% I recommend start Medpass day) and Prostat 30 ml ontor for additional needs." a.m "92 (pounds) (on) 91 (pounds) (on) 1/4; 90 day le); 180 day (weight): 121 eight loss is significant I (body mass index): 15.8 nt status. (The resident) is on with no supplements. (Oral) e): (breakfast) - 64% (lunch) b): (breakfast) - 64% (lunch) b): (breakfast) - 64% (lunch) b): will recommend start eve times a day) to support inue to monitor. P.M "90 (pounds) (on) icant weight loss (times) 90 esident) is on a regular mend Medpass 120 ml Vill monitor. tion was found as part of a e dated 10/14/2020: "Today we resident) 90cc of a day I will continue to o for weight loss and make needed."	F 692	2			

Facility ID: VA0106

If continuation sheet Page 54 of 95

	MENT OF HEALTH AN S FOR MEDICARE & I						FORM	D: 11/05/2021
STATEMENT (STATEMENT OF DEFICIENCIES (X1) PROVIDER/S IDENTIFICATI		ì í				(X3) DATE COMP	LETED
		495135	B. WING			_		C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Med Pass recomment Med Pass 120 ml (thr ordered by a medical nutritional supplement included the following ALREADY PRESCIBE SUPPLEMENT/ASSE ORAL CARE NEEDS The survey team had Administrator, Directo Consultant #1, and Nu 5/12/21 at 12:27 p.m. failure of facility staff t recommendations to a weight loss was discu- information related to the survey team. Facility Hiring and Use CFR(s): 483.35(d)(1)- §483.35(d) Requirement of nurse aides- §483.35(d)(1) General A facility must not use the facility as a nurse months, on a full-time (i) That individual is co and nursing related se (ii)(A) That individual is competency evaluation	dations until 4/6/21 when ee times a day) was provider. (Med Pass is a t.) Resident #44's care plan approach: "IF NOT ED, ASSESS NEED FOR SS & MEET (the resident's) ." a meeting with the facility's r of Nursing, Nurse urse Consultant #2, on During this meeting, the o timely act on dietary address Resident #44's ssed. No additional this issue was provided to e of Nurse Aide (3) ent for facility hiring and use I rule. any individual working in aide for more than 4 basis, unless- ompetent to provide nursing ervices; and has completed a training uation program, or a on program approved by the requirements of §483.151 s been deemed or		692				

Event ID: OGAZ11

Facility ID: VA0106

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495135	B. WING				C / 12/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 728	§483.35(d)(2) Non-per A facility must not use leased, or any basis of employee any individu- requirements in parage this section. §483.35(d)(3) Minimu A facility must not use worked less than 4 m facility unless the indi (i) Is a full-time emplo- training and competen (ii) Has demonstrated satisfactory participati- nurse aide training an program or competen (iii) Has been deemed as provided in §483.1 This REQUIREMENT by: Based on staff intervi- review, and facility do facility staff failed to e 27) of four unlicensed demonstrate competen necessary to care for The findings included For Employee # 27, the ensure a competency was documented. Review of Employee 05/11/2021. Review of Employee # 27 revea	ermanent employees. e on a temporary, per diem, other than a permanent ual who does not meet the graphs (d)(1)(i) and (ii) of m Competency e any individual who has onths as a nurse aide in that vidual- yee in a State-approved ncy evaluation program; competence through ion in a State-approved do competency evaluation cy evaluation program; or d or determined competent 50(a) and (b). is not met as evidenced iew, employee record cumentation review, the nsure that one (Employee # d nurse aides was able to ency in skills and techniques residents' needs. : me facility staff failed to skills proficiency checklist Records was conducted on of the personnel file for	F	728	3		

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/05/2021 APPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495135	B. WING			(05/ ⁻	C 12/2021	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, S	TATE, ZIP CODE			
HERITAG	E HALL BIG STONE GAP			045 VALLEY VIEW DRIVE BIG STONE GAP, VA 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 728 F 740 SS=G	"unlicensed nurses ai the "AHCA (American -NCAL (National Cent Temporary Nurse Aide 7/15/2020. The facility a copy of the compete Employee # 27. On 5/12/2021 at 9:48 conducted with the H who stated the staff d could not find the com Employee 27. The H stated the expectation would be completed a unlicensed nurses aid The Administrator was 05/12/2021 during the No further information Behavioral Health Set CFR(s): 483.40 §483.40 Behavioral h Each resident must re provide the necessary services to attain or m practicable physical, r well-being, in accorda assessment and plan encompasses a resid mental well-being, wh limited to, the prevent and substance use di This REQUIREMENT by:	de." Employee #27 finished a Health Care Association) ter for Assisted Living) es online course" on y staff was unable to provide ency skills checklist for a.m., an interview was luman Resources Director evelopment coordinator npetency skills check list for uman Resources Director n was that a skills checklist and in the file for each de. s advised of the issue on e end of day debriefing. n was provided. rvices ealth services. eceive and the facility must y behavioral health care and haintain the highest mental, and psychosocial ance with the comprehensive of care. Behavioral health ent's whole emotional and hich includes, but is not tion and treatment of mental	F 728					

Event ID: OGAZ11

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_		C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		-
HERITAG	E HALL BIG STONE GAP			045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24	219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	coordinate necessary services to attain the mental, and psycholo residents, Resident # The finding included: For Resident #121, fa behavioral health care resident's guardian, fa behavioral health care ideations resulting in attempts. In one of th was found in room lay with call light tied tigh resident was turning fu untied call light cord, f wished to die. This is Resident #121's diag diagnoses, which incl Mood Disorder due to Condition, Schizoaffe Major Depressive Dis Unspecified, Unspeci Behavioral Disturband Unspecified Cerebrow B12 Deficiency Anem Diabetes Mellitus with Unspecified. The most recent quar set) with an ARD (ass 4/02/21 assigned the interview for mental s section C, Cognitive F was coded as requirin	the facility staff failed to behavioral health care highest practicable physical, gical well-being for 1 of 27 121. acility staff failed coordinate e services between the acility staff, physician, and e services following suicidal three separate suicide three separate suicide ty around neck. The plue and when released and resident stated (he/she) s harm. hosis list indicated uded, but not limited to b Known Physiological ctive Disorder Unspecified, order Recurrent fied Dementia with ce, Dysphagia following vascular Disease, Vitamin ia Unspecified, and Type 2	F 740				

Facility ID: VA0106

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	-	D HUMAN SERVICES				FORM): 11/05/2021 I APPROVED
STATEMENT	CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY LETED
		495135	B. WING		_	(05/ [,]	C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, ST	TATE, ZIP CODE	_	
HERITAG	E HALL BIG STONE GAP			045 VALLEY VIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	dressing, personal hy dependent in transfer Diagnoses, Resident diagnoses of anxiety of schizophrenia, and so unspecified. On 5/04/21 at approxi- observed Resident #1 chair in the common at watching television. S asked the resident ho #121 immediately res- resident further stated pray every day that I whand-held looped stra- within reach, surveyor for and resident stated need them". On 5/04 again spoke with the Surveyor #2 and aske surveyor could look at stated "what's wrong of choke myself" and res- (he/she) "turned it loo Resident then becam- were tired of living. A nursing progress no states "this nurse was nursing assistant) wha and was laying behind neck when asked abo didn't know it was that A subsequent nursing 2/04/21 9:06 pm states	giene, and being totally s. In section I, Active #121 was coded for the disorder, depression, chizoaffective disorder imately 2:45 pm surveyor 121 sitting up in a reclining area with other residents Surveyor introduced self and w they were doing, Resident ponded "depressed". The d "I'd rather be dead" and "I will die". The resident had a up with jingle bells attached r asked what the bells were d "to get the nurses when I /21 at 6:34 pm, surveyor resident in the presence of ed the resident if this t their neck. Resident #121 with my neck, oh I tried to sident further stated se when it started to hurt". e tearful and stated they the dated 2/04/21 8:48 pm a notified by cna (certified en (he/she) went in to ell was pulled out of the wall d and across res (resident) but this res stated (he/she) t way."	F 740				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 11/05/2021 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE S COMPL	SURVEY .ETED
		495135	B. WING			C 05/1	, 2/2021
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
	E HALL BIG STONE GAP		2	2045 VALLEY VIEW DRIVE			
HENHAG	L HALL DIG STONE GAP		E	BIG STONE GAP, VA 2421	19		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTI CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT FICIENCY)		(X5) COMPLETION DATE
F 740	didn't want to hurt (hir didn't know it was tha [sp] (he/she) had prev to hurt (himself/hersel to er res stated (he/sh saying that that I'm life because I say it does Resident #121 was tr and admitted on 2/04, omitted) Discharge Sh states in part, "75-yea in for suspected suice home reports that the (his/her) nurse call lig (his/her) nurse call lig (his/her) neck. The p does not remember th remember any intent (He/she) admits to be (he/she) has no intent (himself/herself). In th have acute blood loss kidney injury) with UT (He/she) was admitte one-to-one"; "Crisis w recommended (he/sh omitted) that can cons practitioner), but (faci Today (he/she) was c (facility name omitted require [sp] COVID 15 being negative (antige Nursing home was no had previously been 0 6th. Because of new patient was transferre	eck res stated (he/she) mself/herself) that (he/she) t way I explained to res were viously said (he/she) wanted if) that (he/she) needs to go he) didn't even remember bel to say anything just in't mean I need it". ansported to the local ER /21. The (hospital name ummary dated 2/09/21 ar-old (male/female) brought dal intent. The nursing y found (him/her) with ht cord wrapped around atient states that (he/she) his nor does (he/she) to hurt (himself/herself). ing depressed but states tion of harming he ER (he/she) was found to a anemia with AKI (acute I (urinary tract infection). d to the ICU with vas consulted and initially e) go back to (facility name sult psychiatry NP (nurse lity name omitted) declined. oordinate [sp] a bed with) for inpatient psych, but D was positive today, after en and 4plex 2/05/21). otified and stated that patient COVID positive status ed to (facility name omitted). make (his/her) own medical	F 740				

Facility ID: VA0106

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED D. 0938-0391
STATEMENT O	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_		C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		-
	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE	E		
HERITAGE	HALL BIG STONE GAP			BIG STONE GAP, VA 2	4219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	Continued From page continued suicidal ideations/depression// Resident #121's Phys from (facility name on in part, "Patient was a (He/she) is still active (He/she) should conti "Patient is now medic have discussed with f omitted) who agrees t and will assist in gettin omitted) inpatient psy Resident #121 was ac omitted) for inpatient p discharged on 2/27/27 resident's clinical records Resident #121 was re 2/27/21 following inpat (facility name omitted) A nursing progress no states "this nurse was cna that res roommat had put call bell arour nurse spoke with res was trying to kill herse when it started to hurt 9:44 pm states "Upon	a 60 dementia". ician Discharge Summary hitted) dated 2/11/21 states also seen by psychiatry. ly suicidal/homicidal. nue full psych precautions"; ally stable for discharge. I hospitalist at (facility name to accept patient in transfer ing patient to (facility name ch as previously planned". dmitted to (facility name ch as previously planned". dmitted to (facility name csych care on 2/13/21 and 1. Surveyor requested the ords on 5/10/21, however, as a had not been received. eadmitted to the facility on tient psychiatric care at .). the dated 4/11/21 7:46 pm a setting at desk was told by e had told (him/her) that res ind (his/her) neck when this (he/she) stated (he/she) elf but (he/she) stopped ". Addendum dated 4/11/21 assessment of res o [sp]	F 74				
	transported to the loca The After Visit Summa	ary from (facility name Department dated 4/11/21 -up with behavioral					

Facility ID: VA0106

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	-	D HUMAN SERVICES					FORM	D: 11/05/2021 APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,				(X3) DATE SURVEY COMPLETED C		
		495135	B. WING			_) 12/2021	
NAME OF P	ROVIDER OR SUPPLIER		-	S	TREET ADDRESS, CITY, ST	TATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	S PLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 740	suicidal precautions". resident's clinical reco omitted) emergency of however, as of 5/18/2 received. A nursing progress no states "res back from only order is verbal or up with (name omitted eyes closed". Resident #121 was set the following day on 4 states in part, "Per nu suicide attempt by wra (his/her) neck and wa attempt and was retur (facility name omitted memory problem. Su (patient currently cons Discussed with patien yesterday. Pt verbaliz I'm glad I don't.' Deni harm/suicidal ideation denies anxiety". Reco "continue constant ob 1:50 pm, surveyor spo DON (director of nurs and asked how long of Resident #121 to rem observation, the DON specify".	Surveyor requested the ords from (facility name lepartment on 5/05/21, 1 the records had not been be dated 4/11/21 11:58 pm (facility name omitted) er der from hospital to follow d) on 4/12/21 res in bed with een by the psychiatric NP 4/12/21, the progress note rsing patient had made a apping call bell around s sent out to E.R. r/t suicide rned back to the facility from) with a diagnosis of bjective: Lying in bed stant observation by CNA). It (his/her) attempt at suicide zed, 'I don't remember that, es thoughts of self is. Endorses depressed; ommendations include servation". On 5/06/21 at oke with the administrator, ing), and the social worker did the psychiatric NP want ain under constant stated "(he/she) didn't	F	740					

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CENTER STATEMENT (AND PLAN OF NAME OF PI		D HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	A. BUILDING	E CONSTRUCTION STREET ADDRESS, CITY, ST 2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24		FORM OMB NO (X3) DATE COMP	LETED
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S (EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	note from the visit sta Resident with progres 7:46 pm, finding Resid around (his/her) neck intent or plan or strem- confronted, Resident of doing that""(He/ wanted to die but den requested that with ea person be appointed, for a one on one with attention and support. be a suicide gesture v out". Resident #121 was se psychologist on 4/28/2 progress note states i session indicated that don't want to live""' started to cry saying ((he/she) did not want expressed in prior ses and no way or strengt expressing is not suic live". Current risk fac was documented as r On 5/06/21 at 6:58 an (licensed practical nut Resident #121 on 2/0 aforementioned incide LPN #1 stated that in the resident with the o their neck and original wanted to hurt (himse	een by the licensed ealth on 4/14/21, progress tes in part, "Approached as note report of 4/11/21, dent with call bell cord . However, no evidence of gth to tighten cord. When said (he/she) had no recall she) said (he/she) still ied intent or plan""It is ach shift change, a staff who would spend 10 mins. Resident for positive . Incident of 4/11 appears to w/o intent or plan to carry een by the licensed 21 via telehealth and in part, "Staff consult prior to t Resident keeps saying 'l 'at end of session (he/she) he/she) could not do it and to live. Resident has asion (he/she) has no plan th to do it. What Resident is idal ideation but no will to tor for suicidal/self injury	F 740				

Facility ID: VA0106

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		MEDICAID SERVICES				O. 0938-039
	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G		E SURVEY IPLETED
		495135	B. WING _		05	C 5/12/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 740	second time (he/she) around (his/her) neck and the CNA came ar the resident had alrea said it started to hurt is Surveyor asked LPN time to prevent it from #1 responded CNAs of one on one care "I thi A nursing progress no states in part "Late no Resident was found in eyes closed with call Resident was found in eyes closed with call Resident was turning and untied call light co wished to die and tha so soon. Vitals were O2 96, Resp 18, Tem while calling transport family". Subsequent 12:39 am states in par pm) transport arrived (he/she) stated (he/sh call light cord around didn't know why (he/st that". The After Visit Summ omitted) Emergency I states in part, "Patien the severity of (his/he really decide to comm so disabled (bed boun to act on a suicidal im have one. There is n (his/her) acting out ar		F7	40		

Facility ID: VA0106

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	MENT OF HEALTH AN						FORM	D: 11/05/2021 APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495135	B. WING			_		C 12/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 740	custody at a psych fac There is just no value call cord from (his/her omitted) is a safe and stay". Surveyor reque records from (facility r department on 5/05/2 the records had not be Nursing progress note states in part "Reside with no new orders no suicidal ideations at th observation and giver needing assistance. If bell and Resident stat understand how to us On 5/10/21 at 1:54 pn #3 who was Resident RN #3 stated Resider and they went to answ with the call light cord neck 2 to 3 times and it. RN #3 stated the re "reddish bruise place" in their neck and neck a rubber band on you call light cord became and caused the light t that "after the fact I was before". Resident #121's curre problem area stating i ideations", care plan a "monitor safety needs	cility to prevent suicide. in this. Please remove the) reach. (Facility name good place for (him/her) to ested the resident's clinical name omitted) emergency 1, however, as of 5/18/21 een received. a dated 5/01/21 9:11 am in tback from ER for EVAL oted. Resident denies is time. Placed on 1:1 in hand bell to ring when Educated on use of hand es 'l'm not too far gone to e a bell'". n, surveyor spoke with RN #121's nurse on 4/30/21. it #121's call light was on ver it and found resident wrapped around (his/her) had to get help to remove esident's neck had a 'where the call light clip was a appeared "like if you wear r wrist". RN #3 stated the unplugged from the wall to come on. RN #3 stated as told (he/she) had done it ent care plan includes the n part "has hx of suicidal approaches include in part, , 1 on 1 monitoring/sitter of crisis", "hand call bell", "In	F	740					

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		495135	B. WING				0 /12/2021
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE		-
HERITAGE	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 740	Continued From page	9 65	F	740			
	spoke with the MDS r the manager on Satu	imately 3:30 pm, surveyor nurse who stated they were rday, 5/01/21, and they gave bells that day and added it					
	Resident #121 was seen for their weekly telehealth visit with the licensed psychologist on 5/05/21, the progress note states in part, "(He/she) added 'I'm depressed out of my mind. I don't want to live'(He/she) continues to express low will to live in terms of praying for god to take (him/her), which is differentiated from active suicidal ideation, intent, or plan at this time." The progress note does not include any documentation of the incident on 4/30/21 when the resident wrapped the call bell cord around their neck. Surveyor could not locate documentation that the psychologist was notified of the 4/30/21 incident.						
	psychologist by leavin 5/06/21 and 5/10/21,	o contact the licensed ng voice messages on however, as of survey exit ad not been returned.					
	the resident's clinical						
	#121's room, the residuation with the left side again electrical cord plugge	imately 6:40 pm, this or #2 observed Resident dent's bed was positioned nst the wall with the bed's d into an outlet on the left ximately two feet above the					

Facility ID: VA0106

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	-	D HUMAN SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495135	B. WING				C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 740	mattress. If the reside electrical cord and ou reach. Surveyor did r the bed on 5/04/21 du survey. Both call lig the call light port on th on the other empty be The resident's over be attached to turn the lig Surveyor #2 discusses with the administrator DON, and nurse conse The following morning approximately 8:00 at resident's room and of staff member in the ro stated they were mov removing the call light resident was suicidal the cords out. Reside during this time. At 1 the resident's room an left side of the bed ha plate covering it and t into an outlet to the rig headboard with a core cord going down the were were removed and the covered with a solid p the over bed light had On 5/06/21 at 1:50 pr administrator, DON (of social worker and dise were taken following of bell cord. The DON s	ent were in the bed, the tlet would be within arm's not observe the resident in uring the first day of the ht cords were plugged into ne wall and cords were lying ed in the resident's room. ed light had a string ght on and off. At 6:55 pm d the room observations , assistant administrator, sultant #1. g, on 5/05/21 at m, surveyor entered the observed a maintenance boom. Maintenance worker ing the bed outlet and t from the room because the and they needed to get all ent #121 was not in the room :06 pm, surveyor observed nd noted the outlet on the d been replaced with a solid he bed was now plugged ght side of the bed's d cover covering over the wall. The call light cords e call light plug in ports were plate. The string attached to	F	740			

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	-						FORM	D: 11/05/2021
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,		CONSTRUCTION		(X3) DATE	0. 0938-0391 SURVEY LETED
		495135	B. WING			_		C 12/2021
NAME OF PROVID	ER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE		
					045 VALLEY VIEW DRIVE			
HERITAGE HAL	L BIG STONE GAP				BIG STONE GAP, VA 24	219		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
read stat sen did (hin see and adn con serv adn time the adn out bed core batt On adn #12 thire sec mis was Sur poli whie Poli The bec b. e. f. atte g.	ed after the secon t to the ER and the not need evaluation n/her) on one to or n by (name omitted) prininistrator stated the tinued until the nurvices decided to di- ninistrator stated the tinued until the nurvices decided to di- ninistrator further size (he/she) was ser call bell cord was ininistrator stated the et, put on a blank 's electrical cord to d from the resident teries. 5/10/21 at 1:45 pm ninistrator and DO the call light cord was d incident. The DC ond incident it was sed" and "I didn't size saying". veyor requested a cy and procedure ch states in part: icy ause of possible size Depressed resider Those with a histo- mpts Those who have	ity. The administrator d incident, the resident was e ER decided that (he/she) on and the facility put he checks until (he/she) was d) psych nurse practitioner sych services. The he one to one checks were rse practitioner and psych scontinue. The tated that after the third at to the ER and sent back, taken away. The hat yesterday they took the cover and wire molded the o the wall and removed the ts radio and replaced it with h, surveyor spoke with the N and asked why Resident vas not removed prior to the DN stated that following the s "something that was see it based on what the ER and received the facility entitled Suicidal Precautions	F	740				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 11/05/2021 APPROVED . 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	PLE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		495135	B. WING			05/ [,]	; 12/2021	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE	_		
HERITAGE	HALL BIG STONE GAP			2045 VALLEY VIEW DRIV				
				BIG STONE GAP, VA 2	24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BI ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 740	organic brain syndrom any talk of death, use (regardless of how mi and must be reported resident's chart. Procedures 2. Maintain safe envi objects, cleaning solu 3. Careful documenta assessment in Clinica On 5/06/21 at 2:59 pr administrator and ask discussed the residen resident's physician o assistance, administra has but I haven't". At they had just spoken and they are okay wit now but if it happens provide services then progress note written 3:16 pm states "This is omitted), Medical Dire regards to resident's r resident being found v resident's neck. (Nan this time (he/she) is c being in facility, howe to ER from this facility attempt to harm self a crisis services for resi will request discharge not being able to prov resident seems to nee	caring for the resident with ne. Any attempt at suicide, lessness of life or attempts nor), are considered serious and written on the ronment by removing sharp tions etc. ation of subjective/objective al Record. In, surveyor spoke with the red if the facility had at's current situation with the r the medical director for ator stated "maybe the DON 3:15 pm, the DON stated with the medical director h the resident being here again and the ER will not discharge (him/her). A by the DON dated 5/06/21 nurse spoke with (name ector of this facility in multiple discharges to ER d/t with cord wrapped around ne omitted) advised that at omfortable with resident ver, if resident is discharged of or this or any other and ER does not provide dent that (name omitted) e from this facility d/t facility ride the extra services ed".	F 74					
	not being able to prov resident seems to nee Surveyor could not loo	vide the extra services ed".						

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	MENT OF HEALTH AN						FORM	D: 11/05/2021 APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING					C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	I IX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 740	health evaluation. Su documentation that the assessed (him/her) for 4/30/21. On 5/10/21 a surveyor spoke with F via telephone. The pl been in the facility in the they were aware of the Resident #121. Phys problem with the ER a them. The physician impossible to get an a psychiatrist. Surveyo feel that Resident #12 they stated "that's a to "guarded yes" and "or On 5/10/21 at 1:20 pr facility medical director #121's history of suici director stated that he Resident #121 as (he patient but the facility resident was sent out director stated that the in the crisis team for to medical director also that an outpatient psy (him/her)". They also watch (him/her) carefi reach, continue to see practitioner, and set s check on (him/her). On 5/06/21 at 2:32 pr (name omitted) Court (adult protective servited)	 5/01/21 without a mental rveyor could not locate e resident's physician had llowing the incident on at approximately 3:30 pm, Resident #121's physician hysician stated they had the last 2 weeks, they stated e three suicide attempts by ician stated they have a and have no control over further stated it is almost appointment with a r asked the physician if they 21 is safe in the facility and bugh one" but it is a verall I think it is". n surveyor spoke with the or concerning Resident de attempts. The medical e was not very familiar with /she) is (name omitted) did notify them when the on 5/01/21. The medical ey do not think the ER called he resident on 5/01/21. The 	F	740				

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			. ,			(X3) DATE SURVEY COMPLETED		
		495135	B. WING				C 12/2021	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STAT	TE, ZIP CODE			
			2	045 VALLEY VIEW DRIVE				
HERITAG	E HALL BIG STONE GAP		E	BIG STONE GAP, VA 242	19			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE	
F 740	stated that this is still worker stated they sp guardian via phone w asked about sending evaluation and the gu not doing what (name ordered and (he/she) sent out. The guardia moved out to another the area ombudsman with the guardian. On 5/05/21 at 4:41 pr facility social worker w does not want the res hospital but did not sa On 5/06/21 at 9:45 ar guardian listed on the Guardian #1 stated (r (Department of Socia of Resident #121 and employees. Guardiar had three suicide atter received conflicting st (he/she) did not do it. have been in contact licensed psychologist minutes of one to one #121 does not need to know someone cares psychologist believes attention. Guardian # guardianship is being and it is currently in th at 12:10 pm, surveyou	attempts, APS further an open investigation. APS oke to the resident's hile onsite at the facility and the resident out for further ardian stated the facility was o mitted) the psychologist did not want the resident facility. APS worker stated was present during the call in surveyor spoke with the vho stated the guardian ident sent out to a psych ay why. In, surveyor spoke with the resident's face sheet. hame omitted) County DSS I Services) has guardianship it includes three DSS if a stated the resident has impts and the first time they cories and the resident said Guardian #1 stated they with (name omitted), the who recommended 20 time each day, Resident o be sent out, they need to . Guardian #1 states the the resident is doing this for e1 stated the resident's changed to (name omitted) ne court system. On 5/06/21 r meet with Guardian #1 and it the facility following their	F 740					

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CENTER STATEMENT (AND PLAN OF NAME OF P		ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495135	A. BUILDING	E CONSTRUCTION	- TATE, ZIP CODE E	FORM OMB NO (X3) DATE COMP	LETED
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 740	Guardian #3 who statt the phone conversation and (name omitted) C evaluation of Resider Guardian #3 stated th Guardian #1's decision reason to send the re- suicidal unless (he/sh Guardian #3 stated th attention and they are of the psychologist. On 5/06/21 at 1:50 pr administrator who stat (name omitted) Coun- facility and had behave willing to evaluate the refused for (name om- evaluate (him/her). S feels the resident is a facility at this time and they are potentially lo the guardian comes a allows evaluation and okay". On 5/12/21 at 10:45 a administrator and ask contact the guardian for a mental evaluation his/her refusal was vo County APS worker. APS was the direct lia (he/she) did not wantt did not want (him/her also asked if the facilit	am, surveyor spoke with ted they were present during on between Guardian #1 County APS when further at #121 was declined. They are in agreement with ons and does not see the sident out as (he/she) is not te) truly hurts themselves.	F 74				

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	-	D HUMAN SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· ,	PLE CONSTRUCTION	-	(X3) DATE SUR COMPLETI		
		495135	B. WING				C 12/2021	
NAME OF PF	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, S	TATE, ZIP CODE			
HERITAGE	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 2				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 740 F 755 SS=D	and if guardianship is The resident's face sh second contact with th "guardian". Surveyor was unable physician or medical of guardian's decision to evaluation being offer County DSS APS. On 5/12/21 at 12:30 p administrator, DON, n nurse consultant #2 s concern of facility faili coordinate care decis suicidal ideations with psychiatric NP, behav medical director. No further information survey team prior to th 5/12/21. Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b)(§483.45 Pharmacy Se The facility must provid drugs and biologicals them under an agreen §483.70(g). The facility personnel to administ	nship is with (name omitted) shared "that's news to us". neet lists Guardian #3 as the ne relationship listed as to locate documentation of director notification of the decline the mental ed by (name omitted) or during a meeting with the nurse consultant #1, and urveyor discussed the ng to follow up and ions related to the resident's the guardian, physician, rioral psychologist, or the was presented to the ne exit conference on edures/Pharmacist/Records 1)-(3) ervices ide routine and emergency to its residents, or obtain ment described in ity may permit unlicensed	F 74					
		es. A facility must provide es (including procedures						

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_		C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
				2045 VALLEY VIEW DRIVE	:		
HERITAGI	E HALL BIG STONE GAP			BIG STONE GAP, VA 24	4219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 755	Continued From page that assure the accura dispensing, and admi biologicals) to meet th §483.45(b) Service C must employ or obtain pharmacist who- §483.45(b)(1) Provide aspects of the provision the facility. §483.45(b)(2) Establist receipt and disposition sufficient detail to ena reconciliation; and §483.45(b)(3) Determo order and that an accu- is maintained and per This REQUIREMENT by: Based on observation record review, facility medications for 1 of 2 Resident # 13 was ad [9/17/17] with diagnos COPD, morbid obesit	 a 73 ate acquiring, receiving, nistering of all drugs and he needs of each resident. onsultation. The facility in the services of a licensed as consultation on all on of pharmacy services in ashes a system of records of a licensed drugs in the accurate bilde an accurate ines that drug records are in ount of all controlled drugs in tool all controlled drugs in tool and the accurate ines that drug records are in ount of all controlled drugs in tool all controlled drugs in tool all controlled drugs in the accurate ines that drug records are in ount of all controlled drugs indically reconciled. is not met as evidenced n, staff interview. and clinical staff administered expired 7 (Resident #13). mitted to the facility ses including lymphedema, y, type 2 diabetes mellitus, 	F 755				
	depressive disorder, a quarterly minimum da with assessment refer resident scored 10/15 mental status and wa of delirium, psychosis care.	cellulitis of lower limb, major and psychosis. On the ta set assessment (MDS) rence date 4/26/21, the 5 on the brief interview for s assessed as without signs , or behaviors affecting M, the surveyor examined					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495135	B. WING _				C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER		·		REET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP				145 VALLEY VIEW DRIVE IG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 755	the south front hall me discovered a Lispro h for Resident #13 whice 3-22-21 expired 4-19- was with the surveyor discovered. Per the April medicati (MAR), the resident re- scale for a blood sugar 4:30 PM; 3 units for b scale on 5/1/2021 at scale for blood sugar AM; 3 units per sliding PM; and 3 units per s 206 on 5/6/2021 at 11	e 74 edication cart. The surveyor umalog insulin pen labeled ch was marked opened c21. The resident's nurse r when the expired pen was on administration record eceived 3 units per sliding ar of 205 on 4/29/2021 at lood sugar 211 per sliding 11:30 AM; 9 units per sliding 305 on 5/2/2021 at 7:30 g scale on 5/3/2021 at 4:30 liding scale for blood sugar 1:30 AM. The resident did pro pen in the medication	F	755			
F 761 SS=D	under Unusable Drug shall not use discontin deteriorated drugs or shall be returned to th destroyed. The director of nursin notified of the concern on 5/6/2021. Label/Store Drugs an CFR(s): 483.45(g)(h)(§483.45(g) Labeling of Drugs and biologicals	biologicals. All such drugs ne dispensing pharmacy or g and administrator were n during a summary meeting d Biologicals (1)(2) of Drugs and Biologicals s used in the facility must be e with currently accepted s, and include the	F	761			

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495135	B. WING				C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
HERITAGI	E HALL BIG STONE GAP				45 VALLEY VIEW DRIVE IG STONE GAP, VA 24219		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		COMPLETION DATE
F 761	Continued From page	9 75	F7	61			
	instructions, and the eapplicable.	expiration date when					
	§483.45(h) Storage o	f Drugs and Biologicals					
		rdance with State and					
		lity must store all drugs and compartments under proper					
		and permit only authorized					
	personnel to have acc	cess to the keys.					
	locked, permanently a storage of controlled of	cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and					
	abuse, except when t package drug distribu quantity stored is min	nd other drugs subject to he facility uses single unit tion systems in which the imal and a missing dose can					
	be readily detected. This REQUIREMENT by:	is not met as evidenced					
	Based on observation failed to remove from	resident's medical supplies n the survey sample (
	under Unusable Drug shall not use discontir deteriorated drugs or	of Medications policy stated, s or Biologicals, "The facility nued, outdated, or biologicals. All such drugs ne dispensing pharmacy or					
	1. For Resident #13, expired insulin.	facility staff failed to discard					
	On 5/06/21 at 2:38 PM	I, the surveyor examined					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION		SURVEY LETED
		495135	B. WING				_ 12/2021
NAME OF PI	ROVIDER OR SUPPLIER		·		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HERITAGE	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 761	discovered a Lispro h for Resident #13 whic 3-22-21 expired 4-19- was with the surveyoud iscovered. The resident did not h the medication cart. 2. For Resident #78, f expired Paroxetine. Resident #78 was add with diagnoses includ schizoaffective disord behavior and hemiple minimum data set ass assessment reference the resident scored 1 for mental status and signs of delirium. The hallucinations and be directed toward other assessment. On 5/06/21 at 10:06 A the North front hall me discovered a card witt expiration date 4/30/2 78. There was anoth paroxetine 10 mg in the The director of nursin	edication cart. The surveyor umalog insulin pen labeled th was marked opened -21. The resident's nurse r when the expired pen was have another Lispro pen in facility staff failed to discard mitted to the facility [8/16/16] ing cerebral infarction, ler, bipolar disorder, violent ogia. On the quarterly sessment (MDS) with e date 3/9/2021, the resident 1/15 on the brief interview was assessed as without e resident did exhibit havioral symptoms not s in the week prior to the AM, the surveyor examined edication cart and h one paroxetine 10 mg and 2021 labeled for Resident # er, unexpired, card with	F	761			
F 842 SS=E	Resident Records - Io		F	842	2		

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE COMP	
		495135	B. WING				_ 12/2021
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		-
HERITAGI	E HALL BIG STONE GAP			2	2045 VALLEY VIEW DRIVE		
				ł	BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	77	F	842	2		
	 (i) A facility may not reresident-identifiable to (ii) The facility may reresident-identifiable to accordance with a conagrees not to use or cexcept to the extent the to do so. §483.70(i) Medical reasides and a standard must maintain medicat that are- (i) Complete; (ii) Accurately docume (iii) Readily accessible (iv) Systematically org §483.70(i)(2) The faciall information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitted with 45 CFR 164.506 (iv) For public health and an enforcement purp purposes, research programmedical examiners, further states and an entering and the states a	lease information that is o an agent only in intract under which the agent lisclose the information ne facility itself is permitted cords. dance with accepted s and practices, the facility al records on each resident ented; e; and ganized lity must keep confidential ned in the resident's records, nor storage method of the release is- r their resident permitted by applicable law; yment, or health care ted by and in compliance activities, reporting of abuse, violence, health oversight administrative proceedings,					

Facility ID: VA0106

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	
	495135 NAME OF PROVIDER OR SUPPLIER						_ 12/2021
NAME OF PF	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
HERITAGE	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
F 842	§483.70(i)(3) The fact record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from th there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The me (i) Sufficient informati (ii) A record of the res (iii) The comprehensiv provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progres (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on interviews documents, it was de failed to ensure comp documentation for six current residents (Res	with 45 CFR 164.512. ility must safeguard medical ainst loss, destruction, or records must be retained required by State law; or e date of discharge when nt in State law; or ars after a resident reaches law. dical record must contain- on to identify the resident; ident's assessments; ve plan of care and services r preadmission screening valuations and locted by the State; 's, and other licensed as notes; and ogy and other diagnostic quired under §483.50. ' is not met as evidenced	F	842			
	1. The facility staff fa	iled to insure Resident #13's					

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	MENT OF HEALTH AN						FORM	D: 11/05/2021 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING					C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP COL	ЭЕ		
HERITAG	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD B		(X5) COMPLETION DATE
F 842	clinical record include episode of vomiting the Resident #13's minima assessment, with an a (ARD) of 4/26/21, was 4/27/21. Resident #1 able to make self und to understand others. interview for mental s score was documented #13 was documented with eating but not as assistance with eating documented as require mobility, dressing, toil hygiene. Resident #1 total dependence for diagnoses included, b blood pressure, diabe disease. During an interview of facility's Administrator at the facility when Re to need to be cleaned clothes they were weat During an interview of facility's Administrator at the facility when Re to need to be cleaned clothes they were weat During an interview of facility's Administrator confirmed the resident did not include inform #13 being found with were wearing. During an interview of	d information about an he resident experienced. um data set (MDS) assessment reference date is signed as completed on 3 was assessed as being erstood and as being able Resident #13's brief tatus (BIMS) summary ed as 10 out of 15. Resident as requiring supervision requiring physical 9. Resident #13 was ring assistance with bed et use, and personal 3 was assessed as having bathing. Resident #13's but were not limited to: high etes, depression, and lung n 5/6/21 at 8:05 a.m., the reported they were present esident #13 was discovered I due to having vomit on the aring. n 5/12/21 at 8:55 a.m., the r and Assistant Administrator it's clinical documentation ation related to Resident vomit on the clothes they	F	842				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING		_		C 12/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From page	80	F 842				
	policy titled "Charting revised date of July 2 to the resident, progre goals, or any changes physical, functional or shall be documented record. The medical r communication betwe team regarding the re response to care I medical record will be or speculative), comp The survey team had Administrator, Director Consultant #1, and Nt 5/12/21 at 12:27 p.m. failure of facility staff t and/or treatment for F resident being found w was discussed. No a to this issue was prov 2. For Resident #90, documentation did no incident. Resident #90 was addi including fracture, arth knee, hypertension, a minimum data set ass reference date 3/19/2 on the brief interview assessed as having s of constant inattentior	een the interdisciplinary sident's condition and Documentation in the objective (not opinionated lete, and accurate." a meeting with the facility's or of Nursing, Nurse urse Consultant #2, on During this meeting, the to document an assessment Resident #13 related to the with vomit on their clothes dditional information related ided to the survey team. facility clinical t match the facility reported mitted with diagnoses nritis, effusion of the left nd hepatitis. On the sessment with assessment 1, the resident scored 0/15 for mental status and was igns of delirium consisting n and disorganized thinking. essed as without signs of					

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING					C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGE	E HALL BIG STONE GAP							
				В	IG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		(X5) COMPLETION DATE
F 842	Describe incident, inc taken: "Resident [#90 facility and resident w by staff. The resident staff and no injuries w APS notified. The res minute checks. Inves report to follow on five	e 81 dent dated 4/19/21 under luding location, and action 0] was found outside the as was assisted by facility t was assessed by nursing vere found. MD, RP, and sident was placed on 15 stigation initiated and final e business days. Under Final ident involving Resident	F	342				
	[#90] has been invest determined that Resid the facility and reside facility by staff. The re- nursing staff and no in and APS notified. The Q15 minute checks 7	igated by the facility. It was dent [#90] was found outside nt assisted back in the esident was assessed by njuries were found. MD, RP, ere resident was placed on 2 hours. No other exit similar to this has happened						
	that date was a nursir "4/19/2021 2:00 AM propelling in hallway a rooms rummaging red times pt's pants pocke papers, gloves, rando bottom of plastic in ha ad opened the door le plastic restored per M times cussing @ staff opening med cart dra the med cart slammed don't need anything ir lighter acting like he w barrier on fire in the h when asked where he	Pt OOB in WC self & in & out of other patients directed behavior numerous ets full of straws, tissue om stuff, pt tore through allway crawled underneath eading outside pt redirected laintenance, pt agitated @ f, when this nurse was wer pt wheeled up beside d it shut twice stating ' you n there get out' pt had a vas going to light the plastic allway lighter confiscated e obtained the lighter he said ocked down stack of folders						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495135	B. WING				C / 12/2021	
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 842	numerous times rumr trying to get in crash of times pt would becom language @ staff, gav throughout the night, swollen. Called [reda behavior new order n X1 dose now DX-Anx The surveyor was una record whether the re- building. The director of nursin under the plastic and constituted an elopen 3. For Resident #101 document the appear the resident's sacrum Resident #1 was adm diagnoses including of essential hypertensio anxiety, and mood dis minimum data set ass reference date 3/10/2 4/15 on the brief inter was assessed as hav delirium (inattention a The resident was not signs of psychosis or Clinical Record review physician order dated dressing to left hip Q3 nurse practitioner (NF had been notified the	naging through drawers cart redirected pt numerous ne angry using vulgar ve pt several snacks pt's (L) knee remains ucted]NP regarding pt's oted Give Vistaril 25 mg po iety". able to determine from the sident actually left the g indicated that crawling opening the door nent. , facility staff did not ance or extent of wounds on and hip. hitted to the facility with lementia, diabetes mellitus, n, major depression,	F	842				

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	-	ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 MAPPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		495135	B. WING					C 12/2021
NAME OF PI	ROVIDER OR SUPPLIER	•		S	STREET ADDRESS, CITY, STATE, Z	IP CODE	-	
HERITAGE	E HALL BIG STONE GAP	,			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BI		(X5) COMPLETION DATE
F 842	A NP note dated 3/17 NP to assess a coccy calcium alginate dress days. No treatments of the si documented on the M administration record include an order to dis dressing. The resident's care pl breakdown related to incontinence, and his care plan did not add On 05/10/21, LPN #1 seen the resident's with documented treatment May. The order was Calcium alginate and went with the surveyor 05/10/21 at 4:10 PM. the sacral wound. The areas with no depth. documented descriptione in the 3/17/21 NF would get an order fo one ordered to better 05/10/21 at 4:21 PM, with normal saline an	notes or skin assessments. 7/21 indicated staff asked the fix wound. The NP ordered a sing to be changed every 3 sacral wound were May 2021 treatment (TAR). The record did not scontinue the sacral lan included "at risk of skin decreased mobility, tory of refusing care". The ress actual wounds. from the skilled unit had not ound. The TAR has no nt of the sacral wound in to clean with NS, apply apply border foam. LPN #1 or to assess the wound on There was no dressing on e wound was several open The most recent ion of the wound was the P note. LPN #1 stated she r a smaller dressing than the fit the affected area. At the nurse washed buttocks d 4x4s ; patted dry with with a cut down calcium	F	842		ENCY)		
	4. For Resident #124	l, facility staff documented						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED	
		495135	B. WING _			C 05/12/2021		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•		
HERITAG	E HALL BIG STONE GAP				045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(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 I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 842	administering pain me administered. Resident #124 was ad diagnoses including h paraplegia, cauda equ back and wrist pain, a the quarterly minimum assessment reference scored 12/15 on the b status and was asses delirium, psychosis, o Per adult protective s investigation docume was missing and not on 2/14/2020 for the n The nurse caring for t documented administ medication with a pain midnight and 6 AM (F administration record) The administrator and notified of the concern on 5/6/2021. 5. For Resident #138 ensure that treatment completed. Resident #138's face which included but no right ankle, unstageal disease, anemia, presuments	edication which was not dmitted to the facility with hypertensive heart disease, uina syndrome, spina bifida, and major depression. On in data set assessment with e date 4/6/21, the resident orief interview for mental used as without signs of or behaviors affecting care. ervice report and facility ints, the resident's Percocet available for administration midnight and 6 AM doses. the resident that night ering the resident's pain in level of 9/10 at both bebruary 2020 medication behaving summary meetings the facility staff failed to is were documented as sheet listed diagnoses of limited to pressure ulcer to oble, peripheral vascular issure ulcer of left heel, e ulcer of sacral region, liabetes, chronic obstructive	F	342				

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	MENT OF HEALTH AN	D HUMAN SERVICES				FORM	D: 11/05/2021 APPROVED 0. 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495135	B. WING		-	(05/	C 12/2021	
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STA	ATE, ZIP CODE			
HERITAG	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 242	219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 842	Continued From page	85	F 842					
	with an ARD (assessing 04/14/2021 assigned interview for mental s C, cognitive patterns. resident is severely or Resident #138's interiand contain a plan for r/t (related to) stage 2 R ankle, sacrum". Inter "tx (treatment) as order Resident #138's clinic contained a signed pt the months of April ar part "Cleanse Right h saline), pat dry, apply cover site daily and P left heel wound with m Santyl ointment, adap and PRN", "Stage 3 to (ankle) cleanse with N pink oval and change "Cleanse sacral wour Santyl ointment, adap daily and PRN". Resident #138's TAR' record) for the month reviewed and contain entries for "Cleanse ridry, apply Santyl ointment, with normal saline, pat adaptive and cover si "Cleanse sacral wour" with normal saline, pat adaptive and cover si "Cleanse sacral wour" santyl ointment, saline, pat adaptive and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" adaptive and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" with normal saline, pat adaptive and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Cleanse sacral wour" saturation of the month reviewed and cover si "Clea	m care plan was reviewed "has impaired skin integrity R (right) hip, bilateral heels, erventions for plan included ered". cal record was reviewed and hysician's order summary for id May 2021, which read in eel wound with NS (normal Santyl ointment, adaptive, RN (as needed)", "Cleanse formal saline, pat dry, apply tive, and cover site daily o right lateral malleolus IS pat dry apply polymem						

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	MENT OF HEALTH AN	D HUMAN SERVICES					FORM	D: 11/05/2021 APPROVED D: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495135	B. WING					C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BI		(X5) COMPLETION DATE
F 842	initialed as completed The entries for "Clear NS, pat dry, apply Sa cover site daily and P wound with normal sa ointment, adaptive an "Stage 3 to right laters pat dry apply polymer (every) day", "Cleans dry, apply Santyl oint cover site daily & PRI completed on 05/07/// Surveyor spoke with t nursing) and RNC (re on 05/11/21 at approx the blank areas on the felt it was a document they would have their days to speak with the Surveyor spoke with f who is the facility's sta on 05/11/21 at approx stated they were work RN #1 stated that APP came into the facility a of the building, and af forgot to initial the treat they do not normally Surveyor spoke with f 05/11/21. Unit manag Resident #138's treat failed to initial the treat RNC #1 stated that the nurse stated they had	on 04/20/21 and 04/26/21. use right heel wound with ntyl ointment, adaptive, and RN", "Cleanse left heel line, pat dry, apply Santyl d cover site daily and PRN", al malleolus cleanse with NS n pink oval and change Q e sacral wound with NS, pat ment, adaptive, 4 x 4 , and N" were not initialed as 21. he DON (director of gional nurse consultant) #1 timately 2:45 pm regarding e TAR's. RNC #1 stated they tation issue. RNC #1 stated hurses that worked these e surveyor. RN (registered nurse) #1, aff development coordinator, timately 3:05 pm. RN #1 ting the floor on 04/20/21. S (adult protective services) and called staff to the lobby ter this, they (RN#1) just atment sheet. RN #1 stated work the floor. JM (unit manager) on er stated they completed ment on 05/07/21, but just	F	842				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D: 0938-0391	
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED		
		495135	B. WING				C 05/12/2021		
NAME OF PF	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STA	TE, ZIP CODE	•		
HERITAGE	E HALL BIG STONE GAP				45 VALLEY VIEW DRIVE G STONE GAP, VA 242	219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE	
F 842	surveyor to confirm, s at this time. The concern of failing documented as comp the administrative tea administrator, DON, F vice-president of oper approximately 12:30 g No further information 6. For Resident #121 document treatment to area to the resident's Resident #121's diagr diagnoses, which incl Mood Disorder due to Condition, Schizoaffe Major Depressive Dis Unspecified, Unspecified Behavioral Disturband Unspecified Cerebrov B12 Deficiency Anem Diabetes Mellitus with Unspecified. The most recent quar set) with an ARD (ass 4/02/21 assigned the interview for mental s section C, Cognitive F Conditions, Resident one unstageable press of wound bed by slow	have said nurse to call ince they were not working to ensure treatments were leted was discussed with m (administrator, assistant RNC #1, RNC #2, regional rations) on 05/12/21 at om a was provided prior to exit. , facility staff failed to o an unstageable pressure left heel. hosis list indicated uded, but not limited to o Known Physiological ctive Disorder Unspecified, order Recurrent fied Dementia with ce, Dysphagia following rascular Disease, Vitamin ia Unspecified, and Type 2 o Diabetic Neuropathy terly MDS (minimum data sessment reference date) of resident a BIMS (brief tatus) score of 3 out of 15 in Patterns. In section M, Skin #121 was coded as having sure ulcer due to coverage gh and/or eschar.	F 8	42					
		cal record included an active ad 2/27/21 stating "US							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495135	B. WING				U /12/2021
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	(unstageable) to left h (normal saline) initially pink cut to fit wound of and change QD (ever Resident #121's April administration record) revealed the treatmer signed off as being co 4/21/21, 4/22/21, 4/23 4/26/21, 4/27/21, 4/25 5/02/21, 5/03/21, 5/04 On 5/06/21 at 3:31 pr (registered nurse) #1 ordered treatment to f #1 stated the area wa Surveyor observed th heel, no redness or dl concerns were identif observation. On 5/06/21 at 4:09 pr (director of nursing) o on the April 2021 and treatment to the resid stated they would che On 5/06/21 at 4:43 pr #2 who stated "I do (h and "it's completely m RN #2 stated they woo on 4/20/21, 4/21/21, 4 and 5/04/21. Surveyor requested a policy entitled, "Chart which states in part: Policy Statement: All	heel cleanse with NS y pat dry apply polymem cover with bordered foam yday)". A review of 2021 TAR (treatment) and May 2021 TAR ht to the left heel was not completed on 4/20/21, 3/21, 4/24/21, 4/25/21, 3/21, 4/30/21, 5/01/21, 4/21, and 5/05/21. h, surveyor observed RN perform the physician the resident's left heel. RN is looking much better. e area to the resident's left rainage were noted and no ied with the wound care n, surveyor notified the DON f the treatment omissions May 2021 TARs for the ent's left heel. The DON	F	842			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495135	B. WING			C 05/12/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG				IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 842 F 886 SS=E	any changes in the refunctional or psychos documented in the re The medical record si communication betwee team regarding the re- response to care. 2. The following infor- in the resident medica c. Treatments or ser The concern of Resid treatment omissions v administrator, DON, r nurse consultant #2 d at 12:30 pm. No further information team prior to the exit COVID-19 Testing-Re CFR(s): 483.80 (h)(1) §483.80 (h) COVID-1 must test residents ar individuals providing s and volunteers, for CO for all residents and fa individuals providing s and volunteers, the L §483.80 (h)((1) Condi- parameters set forth f but not limited to: (i) Testing frequency;	sident's medical, physical, ocial condition, shall be sident's medical record. hould facilitate een the interdisciplinary sident's condition and mation is to be documented al record: vices performed; ent #121's pressure ulcer were discussed with the nurse consultant #1, and furing a meeting on 5/12/21 was provided to the survey conference on 5/12/21. esidents & Staff -(6) 9 Testing. The LTC facility nd facility staff, including services under arrangement OVID-19. At a minimum, acility staff, including services under arrangement TC facility must: uct testing based on by the Secretary, including of any individual specified in psed with		842				

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		ID HUMAN SERVICES MEDICAID SERVICES					FORM): 11/05/2021 APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495135	B. WING				(05/ ⁻	C 12/2021
NAME OF P	ROVIDER OR SUPPLIER	-		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
HERITAG	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	E	(X5) COMPLETION DATE
F 886	(iii) The identification this paragraph with sy consistent with COVII suspected exposure t (iv) The criteria for co asymptomatic individu paragraph, such as th COVID-19 in a county (v) The response time (vi) Other factors spec- help identify and prev transmission of COVI §483.80 (h)((2) Condu- is consistent with curr conducting COVID-19 §483.80 (h)((2) Condu- is consistent with curr conducting COVID-19 §483.80 (h)((3) For ea (i) Document that test results of each staff te (ii) Document in the re- was offered, complete to the resident's testin each test. §483.80 (h)((4) Upon individual specified in symptoms consistent with COVII for COVID-19, take ac transmission of COVI §483.80 (h)((5) Have residents and staff, in services under arrang- refuse testing or are u	of any individual specified in ymptoms D-19 or with known or o COVID-19; nducting testing of uals specified in this ne positivity rate of /; e for test results; and cified by the Secretary that ent the D-19. uct testing in a manner that rent standards of practice for D tests; ach instance of testing: ting was completed and the est; and esident records that testing ed (as appropriate ng status), and the results of the identification of an this paragraph with D-19, or who tests positive ctions to prevent the D-19. procedures for addressing cluding individuals providing gement and volunteers, who	F	886				

Facility ID: VA0106

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		495135	B. WING _			C 05/12/2021		
NAME OF PI	ROVIDER OR SUPPLIER		·	ST	REET ADDRESS, CITY, STATE, ZIP CO	DDE	•	
HERITAGE	E HALL BIG STONE GAP				45 VALLEY VIEW DRIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD B		(X5) COMPLETION DATE
F 886	contact state and local health depa efforts, such as obtain processing test result. This REQUIREMENT by: Based on staff intervi and facility document failed to conduct COV asymptomatic staff ar identified facility COV staff members (LPN # (Resident #92, #109, The findings included The facility staff failed outbreak testing for ou member and three res At the time of the surv COVID-19 positive re- staff member. On 5/04/21 at approxi Entrance Conference administrator stated th COVID-19 positive re- staff member. The fir during this current out 4/12/21. The adminis testing residents with potential exposures o staff twice weekly. Ac	esting supply shortages, rtments to assist in testing ning testing supplies or s. is not met as evidenced ew, clinical record review, review, the facility staff (ID-19 outbreak testing for rd residents during an ID-19 outbreak for 1 of 3 (2) and 3 of 3 residents and #116). to conduct COVID-19 ne asymptomatic staff	F 8	86	DEFICIENC			
	CMS QSO-20-38-NH	August 2020, revised						

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495135	B. WING				C 12/2021
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAGI	E HALL BIG STONE GAP				2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 886	4/27/21 documents in a single new case of staff or residents, all s regardless of vaccina immediately, and all s tested negative shoul to 7 days until testing COVID-19 infection a period of at least 14 of positive result". A review of LPN (licer COVID-19 testing sin COVID-19 testing sin COVID-19 testing sin COVID-19 outbreak of documentation of test only. COVID-19 Test #2 documented a neg On 5/11/21 at 11:10 a IP (infection prevention were present in the far at that time and the re- on 4/13/21. The IP st testing is not mandato A review of Resident outbreak testing docu- resident was tested o results and 5/06/21 w Surveyor was unable COVID-19 testing res 4/12/21 and 5/06/21. A review of Resident revealed the last docu- obtained on 3/24/21 v Surveyor was unable COVID-19 testing res	a part, "Upon identification of COVID-19 infection in any staff and residents, tion status, should be tested staff and residents that d be retested every 3 days identified no new cases of mong staff or residents for a lays since the most recent nsed practical nurse) #2's ce the onset of the current on 4/12/21 revealed ting performed on 4/20/21 form dated 4/20/21 for LPN gative result. Im surveyor spoke with the onist) who stated staff that necility on 4/12/21 were tested tated that staff COVID-19 ory. #92's COVID-19 current imentation revealed the n 4/12/21 with negative ith negative results. to locate documentation of ults obtained between #109's medical record umented COVID-19 test was vith negative results. to locate documentation of	F	886			

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 11/05/2021 APPROVED D: 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495135	B. WING			_	C 05/12/2021		
NAME OF P	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE			
	HALL BIG STONE GAP			20	045 VALLEY VIEW DRIVE				
HERITAGE	TALL DIG STONE GAP			В	IG STONE GAP, VA 24	219			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 886	Continued From page	93	F	886					
	negative results and t COVID-19 test was per positive results. On 5/11/21 at 2:30 pm nursing) stated they "of they returned the surv	was tested on 4/12/21 with he next documented erformed on 4/26/21 with h the DON (director of don't have any of these" as reyor's list of missing							
	and 116. On 5/11/21 at 4:10 pn and discussed the mis testing results. The IF any results for Reside 4/19/21 or 4/26/21, sta	ults for Resident #92, 109, n surveyor spoke with the IP ssing resident COVID-19 P stated they do not have nt #92 or Resident #109 for ating both residents were were not documented. The							
	IP stated for Resident were "probably not do	#116, COVID-19 results cumented for 4/19/21".							
	•	nd received the facility 0-19 Testing Plan" which o an Outbreak							
	2. Upon identification COVID-19 infection in staff, vaccinated and residents should be te	of a single new case of any staff or residents, all unvaccinated, staff and ested, and all staff and							
	every 3 days to 7 day new cases of COVID- residents for a period most recent positive r Filing of Confidential I 1. Employees:	ab Results							
	a. All hard copies ar binder in the Infection	e filed in the COVID-19 Preventionist office.							

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	-	ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 11/05/2021 FORM APPROVED DMB NO. 0938-0391		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495135	B. WING		_	C 05/12/2021		
NAME OF P	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STA	TE, ZIP CODE			
HERITAGI	E HALL BIG STONE GAP			2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 242	219			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)			
F 886	 Residents: Lab results are p physician for signatur record. On 5/11/21 at 4:54 pr administrator, assista nursing, vice presider consultant #1, and nu discussed the concer Resident #109, and F COVID-19 testing res No further information 	rovided to the attending re, then place in the medical n during a meeting with the nt administrator, director of nt of operations, nurse irse consultant #2, surveyor n of LPN #2, Resident #92, Resident #116's missing sults.	F 88	δ				

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