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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	C 09/21/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 09/19/2022 through 09/21/2022. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities. There were no Emergency Preparedness complaints that were investigated during this survey.	E 000		
F 000	INITIAL COMMENTS An unannounced (Medicare/Medicaid) standard survey was conducted 09/19/2022 through 09/21/2022. Significant Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. Complaint number VA00052487 was substantiated with deficient practice. The census in this 60 certified bed facility was 56 at the time of the survey. The survey sample consisted of fourteen (14) current Resident reviews and three (3) closed record reviews.	F 000		
F 658 SS=G	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to	F 658	**F658** **Corrective Action(s):** Resident #54 no longer resides at the facility. The facility medical director has been notified that facility nursing staff did not follow professional standards of clinical practice during medication administration for resident #54. Resident #54 was not properly identified and was administered her roommate's medications.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelia Jonette Coleman LNHA | TITLE: Administrator | (X6) DATE: 10/12/22

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 658	Continued From page 1 follow professional standards of quality for one of 17 residents in survey sample (Resident # 54). Nursing staff did not follow professional standards of clinical practice during medication administration. Resident #54 was not properly identified and was administered the roommate's medications in error. Resident #54 was sent to the emergency room and was admitted to the intensive care unit. Resident #54 developed hypotension (low blood pressure) & bradycardia (low heart rate) which required intravenous (IV) fluids, medication, and continued telemetry (heart) monitoring. This indicated harm. The findings included: Resident #54 was admitted to the facility with diagnoses that included, but not limited to: unspecified kidney injury, hypokalemia, hypomagnesemia, encephalopathy, Parkinson's, and dementia. The MDS (minimum data set) that was completed for Resident #54 was an OBRA Admission Assessment with an ARD (assessment reference date) of 07/02/2021. Resident #54 was assessed with a cognitive summary score of "08", which indicated moderate cognitive impairment. The clinical record was reviewed on 09/20/2022 beginning at approximately 8:30 a.m. The progress note section was reviewed and contained the following: "07/02/2021 10:48 AM During AM medication administration, rsd (resident) was administered wrong medications. Rsd VS (vital signs) obtained. 135/79, 72. 98.2, 18, O2 (oxygen) 96% on RA (room air), family in room at time. MD notified of error. Family requested to send rsd to ED (emergency department) (Name of hospital). 911 activated	F 658	**Identification of Deficient Practices/Corrective Action(s):** All other residents receiving medications may have been potentially affected. The DON/designee will conduct medication pass observations with all licensed nursing staff to identify any failures to not identify residents prior to medication administration. All negative findings will be addressed at the time of discovery to include one on one education with the licensed nurse. **Systemic Change(s):** The facility policy and procedure for medication administration has been reviewed and no revisions are warranted at this time. All licensed nursing staff have been educated on the facility's medication administration policy to include identifying residents prior to administering medications by the regional nurse consultant. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform 2 medication pass observations weekly to maintain compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: October 31, 2022**	

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F 658	Continued From page 2 and report called to ED." On 09/20/2022 at approximately 11:30 a.m., the administrator was asked if the facility had investigated the above incident. The administrator presented the facility investigation of the incident at approximately 1:30 p.m. She was asked if the facility had any follow-up information from the hospital after the resident was sent to the ED. She stated she would look. The facility reported incident contained the following: Incident Date: 07/02/2021 Time: 1000 (10:00 a.m.) Describe Injury: Med. (medication) error Narrative of incident and description of injuries: During AM med. Administration rsd received wrong meds. VS: 135/79, 72, 18, 98,.2, O2 98%, family in room and requesting be sent to ED. Report called to ED." Two witness statements were attached to the Incident report. The first statement contained the following: "This Nurse called in report to (Name of hospital) in regards to the wrong medications given to the pt (patient). Medications as followed: Amlodipine 7.5 mg (antihypertensive) * Vitamin C 1,000 mg (supplement/vitamin) * Calcitrol 0.25 mg (supplement) * Carvedilol 6.75 mg (antihypertensive) * Clonidine 0.2 mg (antihypertensive) * Vitamin B-12 1000 mcg (supplement/vitamin) * Eliquis 2.5 mg (anticoagulant) * Famatodine 20 mg (Given to decrease stomach acid) *	F 658		

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F 658	Continued From page 3 Senna-S 8.6-50 mg (stool softener) * Sevelamer HCL 800 mg (mineral binding agent) * ED nurse stated that none of these medications were of great concern and there was probably nothing they could do, but they would monitor her BP." *NOTE drug indications in () were not part of the witness statement but added for clarification/information. The second witness statement, written by the nurse who made the medication error contained the following: "During AM med. Administration @0920 (9:20 a.m.) rsd was given wrong meds while sitting in the hallway. First day on this hallway with this pt, and I thought she was her roommate...Daughter sitting in doorway & notified that rsd received wrong meds & requested that she be sent to ED for eval (evaluation). Daughter was very understanding & stated to me "that it was okay, don't be upset we all make mistakes, and no one is perfect." Rsd with no s/s (signs/symptoms) of distress or c/o (complaints of) discomfort, then obtained VS: 135/79, 72, 98.2, 18, O2 96%. EMS (emergency medical services) arrived @ 0945 (9:45 a.m.) " Along with the incident report was a "MEDICATION ERROR/OMISSION REPORT" which contained the following: "Wrong medication...medications administered in error: Furosemide 20 mg, Amolidipine 7.5 mg, Vitamin C 500 mg, Calcitrol 0.25 mg, Carvedilol 6.25 mg, Clonidine HCL 0.2 mg, Vitamin B-12 500 mcg (2 tabs), eliquis 2.5 mg, Famatodine 20 mg, Senna S 8.6-50 mg, Sevelamer HCL 800 mg....Physician notified at 0930 (9:30 a.m.)...date 7/2/21. Physician Comments: None, family in room,	F 658		

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F 658	Continued From page 4 requested rsd go to hospital..." At approximately 1:45 p.m. on 9/20/22, the administrator stated, "We actually have the discharge summary from the hospital, I'm not sure why we have it, but here it is." The (hospital) discharge summary contained the following: "Physician Discharge Summary Admit date: 7/2/2021 Discharge Date: 7/3/2021 Admission Diagnosis: Hypotension due to medication Discharge Diagnosis: Hypotension due to medication...Overdose of antihypertensive agent, accidental or unintentional, initial encounter. Indications for Admission: ....presents to the emergency department via EMS with a chief complaint of feeing shaky. Evidently she had been given another patient's oral medication this morning including furosemide 20 mg, sevelamer 800 mg, vitamin B-12 1000 mg, apixaban 2.5 mg, amlodipine 7.5 mg, famotadine 20 mg, vitamin c 1000 mg, carvedilol 6.25 mg, clonidine 0.2 mg and calcitrol 0.25 mg. In the ER, she was initially normotensive (137/63) with normal sinus rhythm (71) with normal respirations (180) and oxygenation on room air (98%). She was awake and alert, Labs revealed a mild anemia with H/H (hemoglobin/hematocrit) 10.8/34.3. CMP (Comprehensive Metabolic Profile) was essentially normal. ECG (electrocardiogram) revealed a sinus rhythm (60) with a RBBB (right bundle branch block) which is unchanged from 6/27/21. Poison Control was contacted and advised observation for 6 hours. She was observed on telemetry and developed sinus bradycardia into the 40's and hypotension in the systolic 70's. She remained alert and was fairly asymptomatic. She was given IV fluids for	F 658		

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F 658	Continued From page 5	F 658		

pressure support and IV calcium gluconate 1000 mg. She had improvement in her BP with this therapy although it remained low and her bradycardia persisted. After 8 hours of observation in the ER I was asked to admit for observation.
Hospital Course: She was admitted to the ICU (intensive care unit) for close observation on telemetry. She received IV fluids for pressure support. She remained in sinus rhythm throughout her stay with some bradycardia in the 40's that has recovered to the 50-60's this morning. She developed no other complicating symptoms. Her labs this morning are stable. Her blood pressure had normalized off IV fluids. I discussed her discharge plans with her daughter who plans to care for her at home with other family. I have placed a referral to home health..."

Entering right after the administrator, the ADON (assistant director of nursing) presented the medication administration policy as requested and stated, "The nurse who gave the wrong meds was reeducated after that happened and the pharmacy came in and did med pass audits." She was asked if a plan of correction had been developed for the incident. She responded, "No."

The facility policy for medication administration contained the following:
"General Dose Preparation and Medication Administration...Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Facility staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct

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F 658	Continued From page 6 resident...During medication administration, facility staff should take all measures required by facility policy and applicable by law, including, but not limited to the following: Identify the resident per facility policy." On 09/20/2022 at approximately 4:00 p.m., the nurse who made the medication error, RN (registered nurse) #3 was interviewed over the phone. She was asked if she remembered the medication error and if so what had happened. She stated, "I was an LPN (licensed practical nurse) then...the resident was sitting in the doorway to her room. She and her roommate were new admissions...I gave her, her roommate's meds." She was asked how that had happened. She stated, "The residents there don't wear armbands. We have to identify them by the picture in their record...neither one of them had a picture in there." She was asked how she identified residents in the case of no picture. She stated, "You hope they don't have dementia and can tell you their name...they have their names on the door and there are typically pictures in there, but with new admits that doesn't always happen." On 09/21/2022 at approximately 9:00 a.m., the administrator and the ADON were asked about the facility policy regarding identification of residents. The administrator stated, "We get a picture of them as soon as they arrive and upload it into the system." She was told what RN #3 had stated about there not being a picture in the record at the time of the medication record. She stated, "I don't know, it's in there now." She was asked if the resident's wore arm bands. She stated, "No." During a meeting with the DON (director of	F 658		

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F 658	Continued From page 7 nursing) the ADON, the nurse consultant, and the administrator, on 09/21/2022 at approximately 9:30 a.m., the above information was discussed. The facility staff were informed that based on the investigation the survey team had identified harm to Resident #54. She was given the wrong medications, was sent to the local emergency room, and subsequently admitted to ICU for telemetry monitoring, administered IV medication, and IV fluids. The administrator was asked if any additional information was available the survey team would review it. No further information was presented prior to the exit conference on 09/21/2022. This is a complaint deficiency.	F 658		
F 757 SS=G	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757	**F757** **Corrective Action(s):** Resident #54 no longer resides at the facility. The facility medical director has been notified that facility nursing staff administered unnecessary medications to Resident #54 after failing to properly identify Resident #54 prior to administration. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving medications may have been potentially affected. The DON/designee will conduct a 100% medication regimen review to identify any unnecessary medications. Additionally, a 100% review of all resident EMR profiles will be completed to ensure that each resident profile has a resident photo attached. All negative findings will be addressed at the time of discovery.	

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F 757	Continued From page 8 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to ensure one of 17 residents (Resident #54) was free from unnecessary medications. Resident #54 was administered her roommate's medications in error and was transferred to hospital, where she required treatment. This indicated harm. The findings were: Resident #54 was admitted to the facility with diagnoses, including but not limited to: unspecified kidney injury, hypokalemia, hypomagnesemia, encephalopathy, Parkinson's, and dementia. The MDS (minimum data set) that was completed for Resident #54 was an OBRA Admission Assessment with an ARD (assessment reference date) of 07/02/2021. Resident #54 was assessed with a cognitive summary score of "08", which indicated moderate cognitive impairment. The clinical record was reviewed on 09/20/2022 beginning at approximately 8:30 a.m. The progress note section was reviewed and contained the following: "07/02/2021 10:48 AM During AM medication administration, rsd (resident) was administered wrong medications. Rsd VS (vital signs) obtained. 135/79, 72. 98.2, 18, O2 (oxygen) 96% on RA (room air), family in room at time. MD notified of error. Family requested to send rsd to ED (emergency	F 757	**Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. All licensed nursing staff have been educated on the facility's medication administration policy and how to identify potentially unnecessary medications by the regional nurse consultant. Additionally, the admissions director and nurse managers have been trained on uploading photos of newly admitted residents to the EMR. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee/pharmacist will complete medication regimen reviews monthly to maintain compliance. Additionally, each new admission profile in the EMR will be reviewed by the DON/designee the next business day to maintain compliance. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: October 31, 2022**	

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F 757	Continued From page 9 department) (Name of hospital). 911 activated and report called to ED." The facility incident report was presented at approximately 1:30 p.m. and contained the following: Incident Date: 07/02/2021 Time: 1000 (10:00 a.m.) Describe Injury: Med. (medication) error Narrative of incident and description of injuries: During AM med. (medication) Administration rsd received wrong meds. VS: 135/79, 72, 18, 98,.2, O2 98%, family in room and requesting be sent to ED. Report called to ED." Two witness statements dated 07/02/21 were attached to the Incident report. The first contained the following: "This Nurse called in report to (Name of hospital) in regards to the wrong medications given to the pt (patient). Medications as followed: Amlodipine 7.5 mg (antihypertensive) * Vitamin C 1,000 mg (supplement/vitamin) * Calcitrol 0.25 mg (supplement) * Carvedilol 6.75 mg (antihypertensive) * Clonidine 0.2 mg (antihypertensive) * Vitamin B-12 1000 mcg (supplement/vitamin) * Eliquis 2.5 mg (anticoagulant) * Famatodine 20 mg (Given to decrease stomach acid) * Senna-S 8.6-50 mg (stool softener) * Sevelamer HCL 800 mg (mineral binding agent) * ED nurse stated that none of these medications were of great concern and there was probably nothing they could do, but they would monitor her BP." *NOTE drug indications in () were not part of the witness statement but added for clarification/information.	F 757		

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The second witness statement, written by the nurse who made the medication error contained the following:
"During AM med. Administration @0920 (9:20 a.m.) rsd was given wrong meds while sitting in the hallway. First day on this hallway with this pt, and I thought she was her roommate...Daughter sitting in doorway & notified that rsd received wrong meds & requested that she be sent to ED for eval (evaluation). Daughter was very understanding & stated to me "that it was okay, don't be upset we all make mistakes, and no one is perfect." Rsd with no s/s (signs/symptoms) of distress or c/o (complaints of) discomfort, then obtained VS: 135/79, 72, 98.2, 18, O2 96%. EMS (emergency medical services) arrived @ 0945 (9:45 a.m.) "

Along with the incident report was a "MEDICATION ERROR/OMISSION REPORT" which contained the following: "Wrong medication...medications administered in error: Furosemide 20 mg, Amolidipine 7.5 mg, Vitamin C 500 mg, Calcitrol 0.25 mg, Carvedilol 6.25 mg, Clonidine HCL 0.2 mg, Vitamin B-12 500 mcg (2 tabs), eliquis 2.5 mg, Famatodine 20 mg, Senna S 8.6-50 mg, Sevelamer HCL 800 mg....Physician notified at 0930 (9:30 a.m.)...date 7/2/21. Physician Comments: None, family in room, requested rsd go to hospital..."

The facility policy for medication administration contained the following:
"General Dose Preparation and Medication Administration...Prior to administration of medication, facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: Facility

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staff should: Verify each time a medication is administered that it is the correct medication, at the correct dose, at the correct route, at the correct rate, at the correct time, for the correct resident...During medication administration, facility staff should take all measures required by facility policy and applicable by law, including, but not limited to the following: Identify the resident per facility policy."

On 09/20/2022 at approximately 4:00 p.m., the nurse who made the medication error (RN #3) was interviewed over the phone. RN #3 was asked if she remembered the medication error and if so what had happened. RN #3 stated, "I was an LPN (licensed practical nurse) then...the resident was sitting in the doorway to her room. She and her roommate were new admissions...I gave her, her roommate's meds."

On 09/21/2022 at approximately 9:30 a.m., the above information was discussed with the DON (director of nursing), the ADON (assistant director of nursing), the nurse consultant, and the administrator.

No further information was presented prior to the exit conference on 09/21/2022.

This is a complaint deficiency.