STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ______ B. WING ______	C 08/15/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 08/14/23 through 08/15/23. One Complaint (VA00059469-Non-compliance with related deficiency) was investigated during the survey. Significant corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The census in this 180 certified bed facility was 157 at the time of the survey. The survey sample consisted of 6 current resident reviews and 1 closed record review.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review, and facility document review, the facility staff failed to provide adequate supervision to prevent accidents for 4 of 7 Residents (Resident #3, Resident #6, Resident #4, Resident #5). Resident #3 was found in the floor of the Alzheimer's unit with head wounds. Resident #3 was transferred to a local hospital. A CT (Cat Scan) was performed and showed a right occipitoparietal calvarial fracture, subdural hematoma, hemorrhagic parenchymal contusion	F 689	**F689** **Corrective Action(s):** An Incident and Accident report has been completed and the responsible party and attending physician have been notified for Resident #3. Resident #3 was ambulating unsupervised when an altercation occurred resulting in Resident #3 falling and hitting head sustaining life threatening injuries. An Incident and Accident report has been completed and the responsible party and attending physician have been notified for Resident #4. Resident #2 observed by staff hitting Resident #4 on the head with two shoes. Residents redirected; Resident #2 was moved to a different room. Every 15 minutes checks x72 hours. No injuries. No further episodes.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9/6/23

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 689	Continued From page 1 in the right cerebellar hemisphere, and multifocal subarachnoid hemorrhage. Resident #3 was placed on comfort care and expired. This is harm. The findings included: Resident #3, was found in the floor of the Alzheimer's unit with head wounds, and was transferred to a local hospital. Resident #3 was placed on comfort care due to their injuries, and subsequently expired. Resident #2 reportedly hit Resident #3, resulting in a head wound. Resident #3's diagnoses included, but were not limited to, diabetes, peripheral vascular disease, and difficulty in walking. On 8/14/23, an entrance conference was conducted with the Director of Nursing. The DON stated that Resident #3 had passed away from their injuries. The DON further stated that the incident was not observed by staff, and the other resident involved, Resident #2 did not have any injuries and no memory of the incident. On 8/14/23, a review was conducted of Resident #3's clinical record. Resident #3's quarterly Minimum Data Set assessment with an assessment reference date of 7/24/23 included a brief interview for mental status summary score of 3 out of a possible 15 points, indicating severe cognitive impairment. Resident #3 required supervision of one person for bed mobility, transfers, walk in room/corridor, and locomotion on and off the unit. Resident #3 was not coded as having any limitations in range of motion in the upper and/or lower extremities or as using any mobility devices.	F 689	An Incident and Accident report has been completed and the responsible party and attending physician have been notified for Resident #5. Resident #2 wandered into another Residents room (Resident #5). Residents are in different rooms but shared a bathroom with a connecting door, resident #5 attempted to help Resident #2 out of the room and Resident #2 hit Resident #5, Resident #5 then hit Resident #2. No injuries to Resident #5, Resident #2 had 2 red areas on their face. Every 15 minutes checks x 72 hours initiated on both residents. Resident #2 was assessed by the NP- Patient stable at baseline requiring redirection due to dementia. A follow-up visit was completed on 6/29/23 NP-Stable. An Incident and Accident report has been completed and the responsible party and attending physician have been notified for Resident #6. Resident #6 told Resident #2 to get away from them. Resident #2 then slapped Resident #6 on the hand and back of head. Every 15 minutes checks continued for another 72 Hours. No injuries. Resident separated. Resident #2 was assessed by the NP on 7/21/23 – stable. Resident #2 RP has agreed to seek alternate placement. Facility has sent the referral to The Commonwealth at Cedar Bluff, SWVA Mental Health Institute, Green Oak Behavior Health, and Lee Health and Rehab.	

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F 689 Continued From page 2

Resident #3's comprehensive care plan (CCP) included the following:
"Requires supervision, assist with all activities of daily living (ADL's).
Falls/Injuries: Requires assist with ADL's, ambulates with supervision. Has an unsteady gait, is unsteady with transitions, and receives psychotropic medication, diagnoses diabetes, peripheral vascular disease, repeated falls, dementia, and osteoporosis.
Cognitive/Delirium/Communication/Visual: Is alert and verbal with confusion noted. Communicates verbally with clear speech. Understood and understands. Resides in a locked memory care unit."

The Director of Nursing (DON) provided the surveyor with a physician order list indicating Resident #3 was receiving medications at the time of the incident on 8/04/23. It included Isosorbide Mononitrate, Namenda, Escitalopram, and Seroquel.

A review was conducted of the clinical record. It read: "8/15/23 1:40 p.m., Certified Nursing Assistant [C.N.A. #1] stated they were at the nurses station with C.N.A. #2, and the Licensed Practical nurse [LPN #1]. We heard yelling, we ran down the hallway and we saw Resident #2 standing in the doorway of another residents room (Resident #6). C.N.A. #2 assisted Resident #2 to the desk. I saw Resident #3 in the floor, tried to wake them up, Resident #3 threw up, and they turned them onto their side. LPN #1 asked me to obtain vital signs, LPN #1 called 911 and we stayed with the resident until the ambulance arrived. C.N.A. #1 stated Resident #6 said they saw it all, and Resident #2 had hit Resident #3 in the face.

F 689

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents may have been affected. The DON/designee will complete a 100% review of all incident and accident reports for the past 90 days for any resident-to-resident altercations secondary to resident behaviors. All residents with altercations will have their comprehensive care plan updated with interventions of appropriate supervision and/or additional needs. Negative findings will be corrected at the time of discovery.

Systemic Change(s):
The facility policy and procedure for Safety and Supervision of Residents has been reviewed and no revisions are warranted at this time. The Director of Nursing and/or the Regional Nurse Consultant will educate all staff regarding mitigation of resident-to-resident altercations to prevent hazards.

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8/04/23 8:26 p.m., LPN #1 documented, The cna's were standing at the nursing station when they heard yelling from the hall. When the nurses and aides got back there, that is where we saw another resident in the floor lying unconscious. The aides got The resident (Resident #2), who hit the other resident out of the room. Resident #2 is now sitting in a chair up at the nursing station. Resident is being sent out for psych evaluation."

On 8/14/23 3:55 p.m., an interview was conducted with Resident #6 (BIMS score 15) who stated they were in their room, Resident #3 had come in to talk with them,(Resident #2) came in here and smacked (Resident #3) in the head, who fell down to the floor in my room, and started bleeding. Resident #6 stated, "When they turned (Resident #3) to the side (Resident #3) began puking." Regarding Resident #2, Resident #6 stated, "[Resident #2] hit me too, but I only got a bruise on my arm."

Due to prior altercations with other residents, Resident #2 was supposed to be closely supervised. On 8/15/23 at 12:28 p.m., the DON stated the incident happened on a Friday at approximately 6:00 p.m. and the activity person had gone, they had tried to find placement to supervise Resident #2, but were not having any luck.

The following Facility Reported Incidents were reviewed:
1. 6/06/23. Resident to Resident altercation. Resident #2 wandered into another Residents room (Resident #5). Residents are in different rooms but shared a bathroom with a connecting door. Resident #5 attempted to help Resident #2

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or designee will perform daily rounds to ensure there are no potential accident hazards present, and proper supervision is being maintained for residents with aggressive behaviors and known resident-to-resident altercations. The DON will bring the incident and accident reports to stand up meeting and review them with the administrator. The administrator and DON will initial each I&A as reviewed and appropriate interventions initiated. All negative findings from resident care rounds and I&A review will be corrected at time of discovery and disciplinary action will be taken as warranted. Results of the daily rounds will be reviewed weekly during the Risk Management Committee Meeting. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.

Completion Date: 9/26/23

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out of the room and Resident #2 hit Resident #5, Resident #5 then hit Resident #2. No injuries to Resident #5, Resident #2 had 2 red areas on their face. Every 15 minutes checks X 72 hours initiated on both residents. Resident #2 was assessed by the NP [Nurse Practitioner] -patient stable at baseline requiring redirection due to dementia. A follow-up visit was completed on 6/29/23 NP-Stable.

2. 7/15/23. Resident to Resident altercation involving Resident #2 and Resident #4. Resident #2 observed by staff hitting Resident #4 on the head with two shoes. Residents redirected; Resident #2 was moved to a different room. Every 15 minutes checks X 72 hours. No injuries. No further episodes.

3. 7/18/23, Resident to Resident altercation. Resident #6 told Resident #2 to get away from them. Resident #2 then slapped Resident #6 on the hand and back of head. Every 15 minutes checks continued for another 72 hours. No injuries. Residents separated. Resident #2 was assessed by the NP on 7/21/23-stable.

On the day of the incident, 2 police officers came to the facility. On 8/14/23 at approximately 4:25 p.m., an interview was conducted via telephone with both of them. Police Officer #1 stated that one of the workers at the nursing home had taken out an ECO (Emergency Custody Order) on Resident #2. They had taken Resident #2 to the hospital, they were violent, confused, couldn't remember what had happened, did not know where they were. Mental health made the decision to release the Resident back to the facility and they are still allowing the resident to roam free. The Resident was not charged due to

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F 689	Continued From page 5	F 689		

their mental capacity but there is still a possibility they may be charged.

8/15/23 9:10 a.m., Police Officer #2 stated when they got to the facility, the scene was chaotic on the Alzheimer's wing. We filtered through the issues and emotions and a resident named (Resident #6) had witnessed the assault. Staff stated a resident had hurt a resident. Resident was still in the floor and had vomit and blood in their hair, and the rescue squad personnel got them out pretty quick. Staff kept making statements that Resident #2 was violent, assaulting staff and other residents. Resident #2 was seated in front of the nurses station, staff present. Resident #2 was talking about past issues, fragments. We got word that Resident #3 was bleeding so severe they were placed on comfort care, and they had since passed away from their wounds. Police officer #2 stated Resident #2 was not violent in their presence (but stated they were not the first officer on the scene), they were seated, they had no clue of the incident. Police officer #2 stated Resident #3's autopsy was completed yesterday but they did not have any results of yet. ECO was done by staff, and the facility tried to refuse to take them back, the hospital had to release the resident. Police Officer #1 had spoken with the director or someone and they let Resident #2 come back. Police officer #2 stated they were unsure if Resident #2 was competent to stand trial.

On 8/14/23 at 1:55 p.m., an observation of Resident #2 was made. Resident #2 was resting in bed, with his eyes open, and responding when spoken to. He stated he loved it back here. No mention of any incidents were made by resident.

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F 689	Continued From page 6 The DON provided the surveyor with copies of hospital records for Resident #3's admission to the hospital on 8/04/23. An excerpt read: "Emergency Department (ED) Provider Notes, date of service 8/04/23 8:37 p.m. past medical history of dementia, hypertension, MI (myocardial infarction)... Patient was either pushed or struck by another patient. It was reported (Resident #3) fell to the ground hitting back of head had loss of consciousness. Physical Exam: Laceration to posterior scalp. Talked with daughter stated she wants patient changed from full code to Do Not Resuscitate [DNR]. I discussed case with palliative care nurse. Patient is given IV Zofran and Compazine for nausea will give Morphine IV. History and Physical, date of service 8/04/23 9:35 p.m. admission date 8/04/23. History of hypertension, dementia, with repeated falls presented to the Emergency Room (ER) from... (nursing home) reported by nursing home staff after they were shoved by another resident and lost consciousness approximately several minutes. When arrived in ER, patient was vomiting uncontrollably as soon (Resident #3) arrived via EMS. In the ER, patient's CT showed traumatic brain injury with subdural and subarachnoid hemorrhage. Patient is an assault and trauma patient. Daughter who is a trauma nurse is at bedside and wants (Resident #3) to be comfortable knowing their poor prognosis and likelihood of (Resident #3) coming out of this injury. (Resident #3) is hypoxic and already aspirated which would cause (Resident #3) to develop worsening respiratory distress. Palliative consulted and agreed to see the patient in consult. Will admit to (hospital) for comfort care. CT scan of the brain completed 8/04/23.	F 689		

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F 689	Continued From page 7 Impression: BRAIN: 1. Right occipitoparietal calvarial fracture. 2. Subdural hematoma involving the cerebellar tentorium bilaterally, greater on the right, with extension on the right inferiorly in the posterior fossa. There is mild mass effect exerted upon the right cerebellar hemisphere. 3. Hemorrhagic parenchymal contusion in the right cerebellar hemisphere. 4. Multifocal subarachnoid hemorrhage. History and Physical date of service 8/06/23 5:03 p.m., Patient was admitted to the floor for intracranial hemorrhage due to injury, started on Phenobarbital for possible seizures, placed on comfort care and was ordered Dilaudid 0.5 every 2 hours as needed for pain. Hospice was consulted and hospice saw patient today and was admitted to inpatient hospice care. Discharge summary signed by the provider at the hospital on 8/06/23 at 3:54 p.m. Admission Date 8/04/23. Date of Discharge 8/06/23. Discharge Diagnoses: Principal Problem: Intracranial hemorrhage following injury. Active Problems: Subarachnoid hemorrhage, subdural hemorrhage, closed fracture of occipital bone with routine healing, assault, scalp contusion, acute respiratory failure with hypoxia, and aspiration pneumonia of both lower lobes due to vomit." Resident #2's diagnoses included, but were not limited to, unspecified dementia unspecified severity with other behavioral disturbances, unspecified dementia severe with agitation, brief psychotic disorder, and bipolar disorder.	F 689		

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F 689	Continued From page 8 Resident #2's quarterly MDS assessment with an ARD of 7/07/23 coded this resident as having problems with long- and short-term memory, and was severely impaired in cognitive skills for daily decision making. Resident #2 was not coded as using a mobility device. An excerpt from Resident #2's CCP read: "Requires assist with some ADL's. Ambulates AD LIB {At Liberty} with supervision. Interventions included, assist with ADL's as needed. Alert and oriented to person. Limited mental abilities due to dementia, confusion, and agitation noted. Interventions included, allow rest breaks between activities, assist to get to preferred activities, provide diversional activities. Alert with confusion noted, communicates verbally with clear speech, usually understood and usually understands, no hearing problems, vision is adequate. Has a diagnosis of psychotic disorder, dementia, bipolar disorder. Resides in a locked memory care unit and is known to pace at times. Interventions included, Social Worker to visit as needed, meds/labs as ordered, pharmacy reviews, explain procedures prior to giving care, approach in a calm manner, reorient with care and as needed, if becomes agitated allow time to calm down before continuing/giving care, and provide a calm environment." Resident #2 was receiving the following medications at the time of the incident, 8/04/23. Donepezil, and Rosuvastatin. Resident #2 was evaluated and medically cleared at a local hospital and returned to the facility. Resident #2 was placed on 1:1 upon their return. Resident #2 was assessed by the FNP on	F 689		

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F 689	Continued From page 9 8/07/23 and was placed on Seroquel 12.5 mg at bedtime. On 8/08/23 the provider discontinued the residents Gabapentin, added Depakote, increased the Seroquel to 25 mg every 12 hours for psychosis, and ordered Alprazolam twice a day as needed for agitation after speaking with the residents spouse. On 8/10/23 the provider discontinued Resident #2's 1:1 beginning 8/11/23 and started every 15-minute checks for 72 hours then every 2-hour checks for 72 hours. On 08/15/23 at 10:45 a.m., a meeting was conducted with the DON, Administrator, Nurse Consultant, and ADON. The DON stated that this unit had 35 residents and was staffed with 1 LPN and 3 C.N.A.'s at the time of the incident. The nurse and 2 C.N.A.'s were at the nurses station charting. The third C.N.A. was at the other end of the hall away from the room where the residents were found. There were no staff actively monitoring Resident #2, or the the other residents in the vicinity of the incident. No further information regarding the incident was presented prior to the exit conference.	F 689		