STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495152	A. Building B. Wing	03/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hall Tazewell	282 Ben Bolt Avenue Tazewell, VA 24651

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 21227 Based on observations, staff interviews, and facility document review, the facility staff failed to ensure personal privacy related to written communications for one (1) of 35 sampled residents (Resident #132). The findings include: The facility staff opened Resident #132's mail prior to providing it to the resident. Resident #132's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/25/24, was signed as completed on 1/29/24. Resident #132 was assessed as able to make self understood and as able to understand others. Resident #132's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #132 was assessed as requiring assistance with bathing and dressing. On the afternoon of 3/5/24, Resident #132 reported their mail was being opened prior to being given to them. On 3/6/24 at 10:07 a.m., the facility's Social Worker (SW) reported two (2) items of mail addressed to Resident #132 had been opened and placed in the SW's mailbox to be given to Resident #132. The SW reported they did not know who had opened the mail. On 3/6/24 at 10:15 a.m., the facility's Business Office Associate (BOA) reported if a resident was their own responsible party, then their mail (such as, junk mail and financial mail) is opened and placed in a folder instead of being given to the resident. The BOA showed the surveyor the folders which contained resident mail. The following information was found in a facility policy titled Resident Rights (with a revised date of February 2021): Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . access to a telephone, mail, and email . communicate in person and by mail, email and telephone with privacy . On 3/6/24 at 4:41 p.m., the survey team met with the facility's Administrator, Director of Nursing, Regional Director of Clinical Services, and Regional Nurse Consultant. During this meeting the finding of facility staff opening residents' mail prior to giving it to the residents was discussed.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 28567 Based on staff interview and clinical record review, the facility staff failed to complete an annual (comprehensive) Minimum Data Set (MDS) assessment within 12 months or 366 days of the previous annual assessment for 1 of 32 residents, Resident #51. The findings included: The facility staff failed to complete an annual MDS assessment within 12 months or 366 days of the previous annual assessment. Resident #51's diagnoses included, but were not limited to, atrial fibrillation, diabetes, and malignant neoplasm of bladder. Section C (cognitive patterns) of Resident #51's annual MDS assessment with an Assessment Reference Date (ARD) of 02/28/24 included a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points. Resident #51's clinical record included an annual MDS assessment with an ARD of 01/31/23. The next annual assessment included an ARD of 02/28/24. Indicating the facility staff did not complete an annual assessment within 12 months or 366 days of the previous annual assessment. On 03/06/24 at 4:46 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Regional Director of Clinical Services, and Nurse Consultant the issue with the MDS assessment was reviewed. On 03/07/24 at 9:00 a.m., during an interview with the MDS coordinator this staff stated they had changed over their software system in October and this residents MDS assessment was missed. No further information regarding this issue was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
NAME OF PROVIDER OR SUPPLIER Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Ben Bolt Avenue Tazewell, VA 24651	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 28567 Based on staff interview and clinical record review the facility staff failed to complete a quarterly Minimum Data Set (MDS) assessment within 3 months or 92 days of the previous quarterly MDS assessment for 1 of 32 Residents, Resident #18. The findings included: The facility staff failed to complete a quarterly MDS assessment within 3 months or 92 days of the previous quarterly assessment. Resident #18's diagnoses included, but were not limited to, diabetes, anxiety, and hypertension. Section C (cognitive patterns) of Resident #18's quarterly MDS assessment with an Assessment Reference Date (ARD) of 10/13/23 included a Brief Interview for Mental Status (BIMS) score of 12 out of possible 15 points. A review of Resident #18's clinical record revealed that the facility staff completed a quarterly MDS assessment on 10/13/23. As of 03/06/24 the facility staff had not completed any further MDS assessments. On 03/06/24 at 4:46 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Regional Director of Clinical Services, and Nurse Consultant. the issue with the missing MDS assessment was reviewed. On 03/07/24 at 9:00 a.m., during an interview with the MDS coordinator this staff stated they had changed over their software system in October and this residents MDS assessment was missed. The MDS coordinator stated they were currently in the process of completing a MDS assessment. No further information regarding this issue was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 21227 Based on staff interviews, facility document review, and clinical record review, the facility staff failed to accurately document the completion dates of resident interview sections of Minimum Data Set (MDS) assessments for two (2) of 35 residents (Resident #120 and Resident #132). The findings include: 1. The facility staff failed to ensure Resident #120's MDS assessments were documented in a manner that accurately reflected the facility staff members assessment of the resident. Resident #120's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/8/24, was signed as completed on 2/13/24. Resident #120 was assessed as able to make self understood and as able to understand others. Resident #120's Brief Interview for Mental Status (BIMS) summary score was documented as a 5 out of 15; this indicated severe cognitive impairment. Resident #120 was assessed as requiring assistance with oral hygiene, toileting hygiene, bathing, and dressing. Resident #120's MDS assessment with an ARD of 2/8/24 indicated multiple parts of the MDS was completed after the ARD. Staff members who were responsible for completing resident interview items documented their assessment with a date later than the 2/8/24 ARD date. (The facility Social Worker signed their section was completed on 2/12/24. A Licensed Practical Nurse (LPN) and a Registered Nurse (RN) signed their sections were completed on 2/13/24.) The following instruction was found in the Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual (October 2019): If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed. On 3/8/24 at 12:22 p.m., the survey team met with the facility's Administrator, DON, RDCS, and Regional Nurse Consultant. During this meeting, the documentation indicating that MDS interviews were completed after the ARD date was discussed. 2. The facility staff failed to ensure Resident #132's MDS assessments were documented in a manner that accurately reflected the facility staff members assessment of the resident. Resident #132's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/25/24, was signed as completed on 1/29/24. Resident #132 was assessed as able to make self understood and as able to understand others. Resident #132's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #132 was assessed as requiring assistance with bathing and dressing. Resident #132's MDS assessment with an ARD of 1/25/24 indicated multiple parts of the MDS was completed after the ARD. Staff members who were responsible for completing resident interview items documented their assessment with a date later than the 1/25/24 ARD date. (The facility Social Worker signed their section was completed on 1/29/24. A facility Registered Nurse (RN) signed their sections were completed on 1/26/24.) (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following instruction was found in the Long-Term Care Facility Resident Assessment Instrument 3.0 User Manual (October 2019): If a staff member cannot sign Z0400 on the same day that he or she completed a section or portion of a section, when the staff member signs, use the date the item originally was completed. On 3/7/24 at 9:56 a.m., the Regional Director of Clinical Services (RDCS) stated MDS interviews should not be completed after the ARD date. On 3/7/24 at 1:11 p.m., the Director of Nursing (DON) and the RDCS reported no documentation was found to indicate the aforementioned MDS interviews were completed on or before the ARD date. On 3/8/24 at 12:22 p.m., the survey team met with the facility's Administrator, DON, RDCS, and Regional Nurse Consultant. During this meeting, the documentation indicating that MDS interviews were completed after the ARD date was discussed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted 42353 Based on clinical record review and facility document review, the facility staff failed to ensure the baseline care plan included dietary orders for 1 of 32 residents in the survey sample, Resident #152. This was a closed record review. The findings included: For Resident #152, the facility staff failed to include dietary orders on the resident's baseline care plan. Resident #152's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Pneumonia, Non-ST Elevation Myocardial Infarction, Persistent Atrial Fibrillation, Heart Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease, and Adult Failure to Thrive. A minimum data set (MDS) with an assessment reference date (ARD) of 12/25/23 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #152's closed clinical record included a Baseline Care Plan dated 12/22/23 and a Baseline Care Plan Summary dated 12/22/23, neither document included diet orders or dietary instructions. The medical provider orders present with the baseline care plan documents, also did not include a diet order. Surveyor requested and received the undated facility policy titled Care Plans-Baseline which read in part .1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include the minimum healthcare information necessary to properly care for the resident including, but not limited to the following .c. Dietary Orders . On 3/08/24 at 12:22 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant, and the Regional Director of Clinical Services and discussed the concern of Resident #152's baseline care plan failing to include dietary orders. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/08/24.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 21227 Based on interviews, clinical record review, and facility document review, the facility staff failed to include the resident in their care plan meeting for one (1) of 35 sampled residents (Resident #132). The findings include: The facility staff failed to include Resident #132 as part of the interdisciplinary team for the development of the resident's care plan. Resident #132's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/25/24, was signed as completed on 1/29/24. Resident #132 was assessed as able to make self understood and as able to understand others. Resident #132's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #132 was assessed as requiring assistance with bathing and dressing. On 3/6/24 at 1:43 p.m., the facility's Social Worker (SW) reported residents who are their own responsible party (RP) are provided a letter with instructions to schedule involvement in the Interdisciplinary Team (IDT) care plan meeting. On 3/6/24 at 1:50 p.m., the SW provided copies of letters provided to Resident #132 on 11/6/23 and 1/22/24. Resident #132's clinical record included documentation of the resident's involvement in the November 2023 care plan development. No documentation was found to address the resident's decision to or not to be involved in the January 2024 care plan meeting. The SW reported Resident #132's clinical record did not include information to address if the resident decided to be involved in the January 2024 care plan development meeting. The following information was found in a facility policy titled Care Planning - Interdisciplinary Team (with a revised date of March 2022): - The interdisciplinary team is responsible for the development of resident care plans. - The IDT includes but is not limited to: . to the extent practicable, the resident and/or the resident's representative . On 3/8/24 at 8:45 a.m., the surveyor met with the facility's Director of Nursing (DON), Administrator, Regional Director of Clinical Services, and the Assistant DON. During this meeting, the absence of documentation to show Resident #132's involvement or choice to not be involved in the IDT care plan development for August 2023 and January 2024 was discussed. The DON reported no documentation related to Resident #132's choice related to involvement in the aforementioned care plan development meetings was found.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 2. For Resident #152, the facility staff failed to complete a nursing assessment, address code status, or obtain a weight following admission to the facility. Facility staff also documented the administration of medications on [DATE] and [DATE] on 19 separate occasions after the resident was discharged to the hospital. This was a closed record review. Resident #152's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Pneumonia, Non-ST Elevation Myocardial Infarction, Persistent Atrial Fibrillation, Heart Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease, and Adult Failure to Thrive. A minimum data set (MDS) with an assessment reference date (ARD) of [DATE] coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. According to Resident #152's demographic face sheet, the resident was admitted to the facility on [DATE] from an acute care hospital. Surveyor reviewed the resident's clinical record and was unable to locate an admission progress note documenting the resident's arrival time or general condition at time of admission. Resident #152's clinical record did not include a nursing assessment of the resident upon admission or at any point during their stay at the facility. Resident #152's clinical record did not include a documented weight or address the resident's code status. A review of Resident #152's clinical record progress notes revealed four (4) separate auto-generated progress notes alerting of drug interactions on [DATE] and the next documented progress note was dated [DATE] at 7:05 AM stating in part Resident's HR [heart rate] in the 30s and resident is not responding to verbal stimuli. Crackles noted bilaterally in lung fields, [name omitted], FNP [family nurse practitioner] notified. Order received to send resident to [name omitted] ER [emergency room] . Resident #152 subsequently expired at the hospital. On [DATE] at approximately 5:00 PM, surveyor spoke with the Director of Nursing (DON) and requested assistance locating any additional admission documentation for Resident #152. Surveyor spoke with the DON again on [DATE] at 8:15 AM and the DON stated they could not find any additional documentation. When asked the reason for the lack of admission assessments and documentation, the DON stated they did not know the reason. Surveyor reviewed Resident #152's [DATE] Medication Administration Record (MAR) and noted the following medications were signed off as being administered by Registered Nurse (RN) #4, however, the resident was no longer in the facility: Atorvastatin [DATE] 9:00 AM, [DATE] 9:00 AM; Ferrous Sulfate [DATE] 8:00 AM, Augmentin [DATE] 9:00 AM, [DATE] 9:00 AM; Budesonide [DATE] 9:00 AM, [DATE] 9:00 AM; Carvedilol [DATE] 9:00 AM, [DATE] 5:00 PM, [DATE] 9:00 AM; Pantoprazole [DATE] 9:00 AM, [DATE] 9:00 AM; Dronabinol [DATE] 9:00 AM, [DATE] 1:00 PM, [DATE] 9:00 AM, Sucralfate [DATE] 12:00 PM, [DATE] 4:00 PM, [DATE] 8:00 AM. Levothyroxine was signed as administered on [DATE] at 6:00 AM, however, this was documented by a nurse other than RN #4. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:16 AM, surveyor spoke with RN #4 regarding their documentation on Resident #152's MAR indicating that medications were administered following the resident's discharge. RN #4 stated the medications were signed off in error as the hold button was directly beside the administration button on the computer and the charting system was new at that time. Surveyor requested and received the undated facility policy titled Administering Medications which read in part .22. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication . Surveyor also requested and received the undated facility policy titled Admission Notes which read in part .1. When a resident is admitted to the nursing unit, the admitting nurse must document the following information (as each may apply) in the nurses' notes, admission form, or other appropriate place, as designated by facility protocol: a. The date and time of the resident's admission .f. The general condition of the resident upon admission .m. A brief description of any disabilities (i.e., blind, deaf, hemiplegia, speech impairment, paralysis, mobility, etc.) .p. The height and weight of the resident; q. A statement indicating that the nursing history and preliminary assessment is completed or has been started . s. Notation as to whether or not advance directives apply . The following information was obtained from a professional reference provided to the survey team by the DON on [DATE] at 10:34 AM, A nursing assessment must be completed for each client at the time of admission to a health care agency (Nursing Interventions & Clinical Skills (4th Edition), [NAME], [NAME], and [NAME], 2007, p. 14). On [DATE] at 12:22 PM, the survey team met with the Administrator, DON, Assistant DON, Regional Nurse Consultant, and the Regional Director of Clinical Services and discussed the concern of staff failing to assess Resident #152 upon admission, obtain a weight, or address code status. Surveyor also discussed the concern of staff documenting the administration of medications after the resident had been discharged from the facility. No further information regarding this concern was presented to the survey team prior to the exit conference on [DATE]. 21227 Based on interviews and the review of documents, the facility staff failed to provide services that met professional standards of practice related to admission assessments and/or documenting resident assessments for two (2) of 35 sampled residents (Resident #152 and Resident #154). The findings include: 1. The facility staff documentation indicated that assessments were completed after Resident #154 had died . Resident #154's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], was signed as completed on [DATE]. Resident #154 was assessed as able to make self understood and as able to understand others. Resident #154's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition. Resident #154 was assessed as requiring assistance with oral hygiene, toileting hygiene, dressing, and bathing. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #154's clinical record had a skin assessment documented as being completed approximately 40 hours after the resident had died . On [DATE] at 3:46 p.m., a Registered Nurse (RN #3) stated the assessment could have occurred prior to the date documented. RN #3 stated sometimes the assessments are completed and then documented at a later date. Resident #154's clinical record had a depression screen assessment documented as being completed approximately 87 hours after the resident had died . On [DATE] at 3:30 p.m., the Social Worker (SW) stated the assessment could have occurred prior to the date it was documented. On [DATE] at 10:34 a.m., the Director of Nursing (DON) provided the survey team with a nursing reference book that was housed on Unit 4 of the facility; the book was titled Nursing Interventions & Clinical Skills 4th Edition ([NAME], [NAME] & [NAME], 2007). The following information was obtained from this professional reference: Making prompt entries is essential in effective documentation . Delays in documentation result in serious omissions and untimely client care delays (Nursing Interventions & Clinical Skills (4th Edition), [NAME], [NAME] and [NAME], 2007, p. 13). The following information was found in a facility policy titled Charting and Documentation (with a revised date of [DATE]): - All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. - Documentation of procedures and treatments will include care-specific details, including: . the date and time the procedure/treatment was provided . On [DATE] at 4:38 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Regional Director of Clinical Services, and Regional Nurse Consultant. During this meeting, the failure of the facility staff to follow professional standards of practice related to documentation was discussed. The DON stated the aforementioned assessments should have been documented when they were completed; the DON stated that assessment completed at a later time should be documented as a late entry.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 28567 3. For Resident #96, the facility nursing staff failed to administer the medication Gabapentin per the providers order. Resident #96's diagnoses included, but were not limited to, diabetes and chronic pain. Section C (cognitive patterns) of Resident #96's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 12/26/23 included a Brief Interview for Mental Status (BIMS) score of 15 out of a possible 15 points. Resident #96's clinical record included a provider order for Gabapentin 800 mg four times a day for neuropathy. The order date was documented as 09/11/23. A review of the Medication Administration Records (MARs) for 02/24 revealed that on 02/14/24 at 9:00 a.m. Registered Nurse (RN) #5 documented a 9 for this medication. Per the MAR a 9=other see progress note. Resident #96's clinical record included a progress note dated 02/14/24 transcribed by RN #5 that read, Gabapentin Oral Tablet 800 MG Give 1 tablet by mouth four times a day for Neuropathy On order. Waiting on pharmacy to deliver. A review of the backup supply of medication list revealed this medication would have been available onsite for administration. On 03/07/24 at 11:30 a.m., the Director of Nursing (DON) was notified that Resident #96's Gabapentin was not administered and was available in the stat box (cubex) for administration. The DON identified the nurse that failed to administer the medication as RN #5 and stated they were not working today and only worked PRN (as needed). On 03/07/24, the facility staff provided the surveyor with a copy of their policy titled, Administering Medications. This policy read in part, .Medications are administered in accordance with prescriber orders, including any required time frame . No further information regarding this issue was provided to the survey team prior to the exit conference. 42353 Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide care and treatment according to medical provider orders for 2 of 32 residents (Resident #152 and #96) reviewed and failed to ensure care for a percutaneous cholecystectomy drain for 1 of 1 residents (Resident #62) reviewed with a percutaneous drain. The findings included: (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE: 282 Ben Bolt Avenue Tazewell, VA 24651	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. For Resident #62, the facility staff failed to obtain provider orders directing the care to a percutaneous cholecystectomy drain present on admission. Resident #62's diagnosis list indicated diagnoses, which included, but not limited to Chronic Respiratory Failure with Hypoxia, Acute Cholecystitis, Enterocolitis due to Clostridium Difficile, Peripheral Vascular Disease, Paroxysmal Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Chronic Ischemic Heart Disease, and Type 2 Diabetes Mellitus. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 1/28/24 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #62's comprehensive person-centered care plan included a focus area dated 2/09/24 stating in part The resident has an alteration in gastrointestinal status r/t (related to) DX (diagnosis) cholecystitis, sepsis, and has a biliary drain . A 1/23/24 Clinical Admission assessment documented a biliary drain to the right abdomen. The resident's Discharge Summary from the transferring hospital documented the presence of a percutaneous cholecystectomy tube. On 3/06/24, surveyor reviewed Resident #62's current medical provider orders and was unable to locate orders for the care and/or monitoring of the resident's percutaneous cholecystectomy drain tube. On 3/06/24 at 4:46 PM, the survey team met with the Administrator, Director of Nursing, Regional Nurse Consultant, and the Regional Director of Clinical Services and discussed the concern of Resident #62 having no orders directing care of the percutaneous cholecystectomy drain tube. As the surveyor approached the nurse's station on 3/07/24 at 8:23 AM, the Unit Manager (UM) was on the telephone requesting directions for care for the resident's percutaneous cholecystectomy drain tube. A nursing progress note dated 3/07/24 at 9:10 AM read This nurse called and spoke with (name omitted) the charge nurse at (name omitted) Hospital. This nurse questioned in regards to Chole (cholecystectomy) Drain, whether it needs flushed or not and to clarify the dsg (dressing) changes. She stated that they flushed it while (he/she) was in their care, butthat [sic] it doesn't need flushed daily, but may flush Chole Drain only if drain becomes clogged and doesn't drain properly. Also stated that dsg doesn't have to be changed qd (every day), but qwk (every week). Thus new orders as follows: May flush Chole Drain only if drain becomes clogged and doesn't drain properly with 3ML (milliliters) of Normal Saline flush 0.9%. Change Chole Drain dsg Qwk & (and) PRN (as needed). cleanse [sic] with wound cleaner, pat dry, cover with split gauze and secure with tape. On 3/07/24 at 9:09 AM, surveyor spoke with Licensed Practical Nurse (LPN) #8 who stated the resident went out to an appointment with the surgeon on 2/01/24 and the only care instructions were to cover the area with a dry dressing weekly and when needed. On 3/07/24 at 9:20 AM, surveyor spoke with Resident #62 who stated staff had changed the dressing twice since they were admitted , and staff flush the tube with saline and empty the collection bag about once a week. The resident pulled up their clothing revealing the drain tube with a clean, intact, dry dressing surrounding the area. No date was visible on the dressing. The Regional Director of Clinical Services was informed of the resident's statement. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Ben Bolt Avenue Tazewell, VA 24651	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 3/08/24. 2. For Resident #152, the facility staff failed to administer the following medications as ordered by the provider on 12/24/23: Atorvastatin (statin used to lower cholesterol), Ferrous Sulfate (iron supplement), Budesonide Inhalation (corticosteroid used to treat/prevent inflammation in the lungs), Carvedilol (beta-blocker used to treat heart failure and high blood pressure), Pantoprazole (proton-pump inhibitor used to decrease stomach acid), Dronabinol (cannabinoid used to treat nausea, vomiting, and loss of appetite), and Sucralfate (protectant used to treat and prevent intestinal ulcers). This was a closed record review. Resident #152's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Pneumonia, Non-ST Elevation Myocardial Infarction, Persistent Atrial Fibrillation, Heart Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease, and Adult Failure to Thrive. A minimum data set (MDS) with an assessment reference date (ARD) of 12/25/23 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #152's medical provider orders included the following medication orders: Atorvastatin 10 mg one tablet by mouth in the morning for lipidemia; Ferrous Sulfate 325 milligrams by mouth in the morning for anemia; Budesonide Inhalation Suspension 0.25 mg/2ml, inhale 4ml every morning and at bedtime for dyspnea (shortness of breath); Carvedilol 12.5 mg one tablet by mouth two times a day for hypertension; Pantoprazole 40 mg one tablet by mouth every morning and bedtime for Gastroesophageal Reflux Disease; Dronabinol 2.5 mg one capsule by mouth three times a day for appetite; and Sucralfate 1 gm one tablet by mouth four times a day for Gastroesophageal Reflux Disease. According to Resident #152's December 2023 Medication Administration Record (MAR) documentation for 12/24/23, Ferrous Sulfate was not administered at 8:00 AM, Atorvastatin, Budesonide, and Pantoprazole were not administered at 9:00 AM, Carvedilol was not administered at 9:00 AM and 5:00 PM, Dronabinol was not administered at 9:00 AM and 1:00 PM, and Sucralfate was not administered at 8:00 AM, 12:00 PM, and 4:00 PM. Surveyor was unable to locate documentation on the MAR or in the resident's clinical record explaining the reason for the medication omissions. According to Resident #152's December 2023 MAR documentation for 12/24/23, Sucralfate was not administered at 8:00 PM and Budesonide, Pantoprazole, and Dronabinol were not administered at 9:00 PM due to the resident sleeping. Surveyor requested and received the undated facility policy titled Administering Medications which read in part .4. Medications are administered in accordance with prescriber orders, including any required time frame . On 3/08/24 at 12:22 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant, and Regional Director of Clinical Services and discussed the concern of Resident #152 not receiving medications as ordered by the provider on 12/24/23. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Heritage Hall Tazewell		STREET ADDRESS, CITY, STATE, ZIP CODE 282 Ben Bolt Avenue Tazewell, VA 24651	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 3/08/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495152	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/08/2024
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. 42353 Based on staff interview and facility document review, the facility staff failed to ensure the daily nurse staffing postings included the required resident census information for 11 of 36 days reviewed. The findings included: Surveyor reviewed the daily nurse staffing sheets from 2/01/24 through 3/07/24 and the daily resident census was not documented on the following days: 2/03/24, 2/04/24, 2/10/24, 2/11/24, 2/17/24, 2/18/24, 2/24/24, 2/25/24, 3/01/24, 3/02/24, and 3/03/24. On 3/07/24 at 4:38 PM, the survey team met with the Administrator, Director of Nursing (DON), Regional Nurse Consultant, and the Regional Director of Clinical Services and discussed the concern of the nurse staffing postings failing to include the resident census on 11 separate days. On 3/08/24 at 1:42 PM, surveyor spoke with the DON and asked if there was any additional information regarding this concern, DON stated the staff member did not write the census on the form for those days. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/08/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42353 Based on clinical record review and facility document review, the facility staff failed to ensure residents were free of significant medication errors for 1 of 35 residents in the survey sample, Resident #152. This was a closed record review. The findings included: For Resident #152, the facility staff failed to administer the antibiotic, Augmentin on two separate occasions on 12/24/23. Resident #152's diagnosis list indicated diagnoses, which included, but not limited to Metabolic Encephalopathy, Pneumonia, Non-ST Elevation Myocardial Infarction, Persistent Atrial Fibrillation, Heart Failure, Type 2 Diabetes Mellitus, Chronic Kidney Disease, and Adult Failure to Thrive. A minimum data set (MDS) with an assessment reference date (ARD) of 12/25/23 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #152's provider orders included an order dated 12/23/23 for Augmentin 500-125 mg give one (1) tablet by mouth every 12 hours for Pneumonia for five (5) days. According to Resident #152's December 2023 Medication Administration Record (MAR), the resident did not receive the scheduled 9:00 AM dose of Augmentin on 12/24/23. Surveyor was unable to locate documentation on the MAR or in the clinical record explaining the reason for the 9:00 AM omission. The 12/24/23 9:00 PM scheduled dose of Augmentin was documented on the MAR as not being administered because the resident was sleeping. Surveyor requested and received the undated facility policy titled Administering Medications which read in part .4. Medications are administered in accordance with prescriber orders, including any required time frame . On 3/08/24 at 12:22 PM, the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Nurse Consultant, and Regional Director of Clinical Services and discussed the concern of Resident #152 not receiving the Augmentin as ordered on 12/24/23. No further information regarding this concern was presented to the survey team prior to the exit conference on 3/08/24.