

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495261	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/29/2025
NAME OF PROVIDER OR SUPPLIER Heritage Hall-Leesburg		STREET ADDRESS, CITY, STATE, ZIP CODE 122 Morven Park Road NW Leesburg, VA 20176	
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)		
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and clinical record review, the facility staff failed to provide accommodations of resident needs by ensuring the call bell (a device with a button that can be pushed to alert staff when assistance is needed) was within reach for two of 44 residents in the survey sample, Residents #19, (R19) and R67.</p> <p>The findings include:</p> <p>1. For R19, the facility staff failed to keep the call bell within reach.</p> <p>R19 was admitted to the facility with a diagnosis that included by not limited to difficulty breathing.</p> <p>On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/07/2024, R19 scored 12 out of 15 on the BIMS (brief interview for mental status), indicating R19 was moderately impaired of cognition for making daily decisions.</p> <p>On 01/27/25 at approximately 7:44 p.m. an observation revealed R19 lying in bed. When asked to locate the call bell R19 was unable to find it and stated she did not know where the call bell was located. Observation of the bed revealed the call bell hanging from the underside of the bed. After being informed of the location of the call bell, R19 was asked if she could reach the call bell. R19 stated no.</p> <p>On 01/29/2025 at approximately 9:03 a.m. an interview was conducted with [NAME] CNA (certified nursing assistant) #1 regarding the placement of a resident's call bell. She stated that the call bell is placed within the resident's reach, clipped to the resident's blanket in front of the resident. CNA #1 further stated the resident's call bell placement should be checked each time staff go into the resident's room.</p> <p>The facility's policy Answering the Call Light it documented in part, General Guidelines. 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.</p> <p>On 01/29/2025 at approximately 12:20 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, assistant administrator and ASM #3, director of nursing, were made aware of the above findings.</p> <p>(continued on next page)</p>		

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
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No further information was presented prior to exit.</p> <p>2. For R67, the facility staff failed to keep the call bell within reach.</p> <p>R67 was admitted to the facility with a diagnosis that included by not limited to muscle weakness.</p> <p>On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/06/2025, R67 scored 2 (two) out of 15 on the BIMS (brief interview for mental status), indicating R67 was severely impaired of cognition for making daily decisions.</p> <p>On 01/28/25 at approximately 8:46 a.m., an observation revealed R67 slouched in bed, leaning to the right side, the head of the bed raised. Observation of call bell revealed it was clipped to top left corner of the mattress at the head of the bed.</p> <p>On 01/28/25 at approximately 8:52 a.m., an observation of R67, the call bell and interview were conducted with CNA (certified nursing assistant) #1. When asked if R67 could reach the call bell, CNA #1 stated the call bell was not withing R67's reach.</p> <p>On 01/29/2025 at approximately 9:03 a.m. an interview was conducted with CNA (certified nursing assistant) #1 regarding the placement of a resident's call bell. She stated , The call bell is placed within the resident's reach, clipped to the resident's blanket in front of the resident. CNA #1 further stated, The resident's call bell placement should be checked each time staff go into the resident's room.</p> <p>On 01/29/2025 at approximately 12:20 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, assistant administrator and ASM #3, director of nursing, were made aware of the above findings.</p> <p>No further information was presented prior to exit.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide respiratory care and services for one of 44 residents in the survey sample, Resident #32 (R32).</p> <p>The findings include:</p> <p>For R32, facility staff failed to store the incentive spirometer (1) in a sanitary manner.</p> <p>R32 was admitted to the facility with a diagnosis that included by not limited to generalized muscle weakness.</p> <p>On the most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/23/2024, R32 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating R32 was cognitively intact for making daily decisions.</p> <p>On 01/28/25 at approximately 8:18 a.m., an observed revealed R32 lying in bed. Observation of an incentive spirometer laying on top of the bedside table inside a plastic bag. Further observation revealed the mouthpiece of the incentive spirometer hanging outside of the bag resting on the bedside table.</p> <p>On 01/28/25 at approximately 11:20 a.m., an observed revealed R32 lying in bed. Observation of an incentive spirometer laying on top of the bedside table inside a plastic bag. Further observation revealed the mouthpiece of the incentive spirometer hanging outside of the bag resting on the bedside table.</p> <p>The physician's order for R32 documented in part, Encourage resident to use incentive spirometer q (every) shift as tolerated. For respiratory therapy. Order date: 10/15/2024.</p> <p>On 01/28/2025 at approximately 11:25 a.m., an interview was conducted with R32 regarding the use of the incentive spirometer. R32 stated that He used the spirometer.</p> <p>On 01/29/2025 at approximately 12:25 p.m., an interview was conducted with LPN (licensed practical nurse) #3 regarding the storage of a resident's incentive spirometer when not in use. She stated, The spirometer including the mouthpiece should be kept in a plastic bag to keep it from being contaminated.</p> <p>On 01/29/2025 at approximately 12:20 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, assistant administrator and ASM #3, director of nursing, were made aware of the above findings.</p> <p>No further information was presented prior to exit.</p> <p>References:</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>(1) A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>Based on staff interview, clinical record review, and facility document review, staff interview, the facility staff failed to maintain a resident free of unnecessary medications for one of 44 residents in the survey sample, Resident #97 (R97).</p> <p>The findings include:</p> <p>For (R97), facility staff failed to administer a prn (as needed) the pain medication Oxycodone (1) within the physician ordered pain level parameters.</p> <p>(R97) was admitted to the facility with a diagnosis that included but was not limited to back pain.</p> <p>On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 01/22/2025, R97 scored 15 out of 15 on the BIMS (brief interview for mental status), indicating (R15) was cognitively intact for making daily decisions.</p> <p>The physician's order for R97 documented in part, oxycodone (pain medication) HCl (hydrochloride) Oral Tablet 5 (five) MG Milligrams). Give 1 (one) tablet by mouth every 6 (six) hours as needed for pain as needed for pain rate >6/10 (greater than six out of ten). Order Date: 11/26/2024.</p> <p>The eMAR (electronic medication administration record) for R97 dated December 2024 documented the physician order as stated above. Further review of the eMAR revealed that R97 received five milligrams of Oxycodone on 12/05/2024 with pain level of five, 12/09/2024 with pain level of five, 12/20/2024 with pain level of five, 12/21/2024 with pain level of five, and on 12/31/2024 with pain level of three.</p> <p>The eMAR (electronic medication administration record) for R97 dated January 2025 documented the physician order as stated above. Further review of the eMAR revealed that R97 received five milligrams of Oxycodone on 01/03/2025 with pain level of three and on 01/23/2025 with pain level of five.</p> <p>On 01/29/2025 at approximately 9:25 a.m., an interview was conducted with LPN (licensed practical nurse) #2. After reviewing the physician's order for oxycodone and the eMARS dated above for R97, LPN #2 was asked about the administration of pain medication on the dates listed above. LPN #2 stated, The physician's order was not followed for the administration of oxycodone.</p> <p>The facility's policy Medication Administration. General Guidelines documented in part, Medication Administration: 1. Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate.</p> <p>On 01/29/2025 at approximately 12:20 p.m., ASM (administrative staff member) # 1, administrator and ASM # 2, assistant administrator and ASM #3, director of nursing, were made aware of the above findings.</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>No further information was presented prior to exit.</p> <p>References:</p> <p>(1) Oxycodone is used to relieve moderate to severe pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682132.html.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to ensure a medication error rate less than five percent for one of three residents observed during the medication administration observation, Resident #23. During the medication administration observation, two errors out of 29 opportunities occurred, resulting in a 6.9 percent medication error rate.</p> <p>The findings include:</p> <p>For Resident #23 (R23), LPN (licensed practical nurse) #1 failed to administer gabapentin and Breo Ellipta per physician's orders.</p> <p>A review of R23's clinical record revealed a physician's order dated 1/29/24 for gabapentin 100 mg (milligrams)- one capsule by mouth in the morning for pain and a physician's order dated 5/2/24 for Breo Ellipta 100/25 mcg (micrograms)- one inhalation in the morning for chronic obstructive pulmonary disease (lung disease), rinse mouth with water post use.</p> <p>On 1/28/25 at 7:38 a.m., an observation of LPN #1 preparing and administering medications to R23 was conducted. LPN #1 administered two capsules (instead of the physician prescribed one capsule) of gabapentin 100 mg to the resident. Also, LPN #1 failed to offer/assist R23 with rinsing her mouth with water after the Breo Ellipta was administered.</p> <p>On 1/28/25 at 1:28 p.m., an interview was conducted with LPN #1. LPN #1 reviewed R23's physician's orders. LPN #1 stated, I administered two capsules of gabapentin to R23, and I should have only administered one capsule. LPN #1 further stated, I should have assisted R23 with rinsing her mouth after the Breo Ellipta administration.</p> <p>On 1/28/25 at 4:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the assistant administrator), and ASM #3 (the director of nursing) were made aware of the above concerns.</p> <p>The facility policy titled, Medication Administration documented, 3. Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record.</p> <p>No further information was presented prior to exit.</p>		