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	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hall Lexington	205 Houston Street East Lexington, VA 24450

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview, facility documentation review, clinical record review, and in the course of a complaint investigation failed to post grievance information and failed to ensure an accurate grievance process for one resident, Resident #30 (R30) out of a survey sample of 19 residents. The findings included:1.The facility failed to ensure that grievance forms were readily available to residents and failed to identify and communicate who the designated grievance officer was at the facility. On 8/26/25 at 1:45 p.m., an observation was made in the facility. There were no grievance forms available for residents to submit their concerns, and there was no posting of the grievance officer's name or contact information. On 8/26/25 at 2:00 p.m., a meeting was held with the resident council members. During the meeting, several residents stated they were not aware of who the grievance officer was or how to file a grievance. This had limited their ability to voice concerns and ensure grievances were addressed. On 8/26/25 at 3:49 p.m., an interview was conducted with the director of nursing regarding the grievance process. She stated she would have to defer to the administrator, as she was not sure how far he was from educating staff and residents about the new grievance process. She explained the new process involved staff entering grievances int the computer system, but residents could also give concerns to any staff member. She further explained that under the previous process, concerns were given to the department head, investigated, and a resolution provided. If the resident was not satisfied, another resolution would be sought. During the interview, the nurse consultant brought in a QR code (taken from the restroom posting) that residents could scan for grievances; however, this had not been communicated to the residents. Several residents were interviewed regarding the posting in their rooms. They stated that the posting only appeared to ask for general feedback about how they liked the facility and did not explain the grievance process. When asked if they had cell phones to scan the QR code, the majority of residents reported they did not have cell phones. On 8/26/25 at 4:05 p.m., an interview was conducted with the administrator regarding the grievance process. He stated a new grievance process had been implemented and that QR codes were placed in all areas of the facility and in resident rooms. He reported he had educated residents at a resident council meeting and informed them that he was the grievance officer. When asked to provide evidence that he attended the resident council meeting to provide this education, no evidence was provided. The administrator further acknowledged that, technology is great but not for this population, and (continued on next page)

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

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated he would request approval from corporate to return to a paper version of the grievance process. On 8/27/25 at 9:20 a.m., an interview was conducted with a certified nursing assistant, CNA#4 (CNA4). She stated residents tell her their issues, which she immediately reports to the nurse. She follows up with the assistant director of nursing or director of nursing to ensure it was addressed. The CNA4 said, we don't have paperwork back here to file a grievance. I don't know who the grievance officer is. I would assume the social worker. I have not been made aware of the new grievance procedure. She further stated there were QR codes in resident rooms, but she did not know what they were for. She recalled seeing QR codes in the bathroom and by the time clock, and at the facility entrance. CNA4 stated that she had never seen grievance forms available for residents or staff, nor had she seen the grievance officer posted. On 8/27/25 at 10:05 a.m., an interview was conducted with the staff scheduler, CNA#5 (CNA5). She stated she believed the administrator was the grievance officer. She reported that she would fill out a, Stop and Watch, paper if she needed to report something, which served as documentation that she informed the nurse, and she would then follow up with the administrator. She stated she believed grievance forms may be available at the nurse's station but was not sure. The CNA5 further stated she would go to the administrator to file a grievance. She acknowledged that QR codes were posted in the bathrooms but stated, No one has told me what they are for. I think they are for the family to file a survey, but not a grievance concern. They have been in the bathrooms since I started here last October. On 8/27/25 at 10:14 a.m., an interview was conducted with a licensed practical nurse, LPN#4 (LPN4). LPN4 stated there were grievance forms, but she thought they were completed only if a staff member removed another staff member. She stated she believed the administrator was the grievance office but was unsure. She reported she had not paid attention to whether grievance forms were available to residents and had never personally completed one. She stated she thought they might be kept near the front office but was not sure. LPN4 further stated she did not know if there was a posting identifying the grievance officer and had never seen one. On 8/27/25 at 10:23 a.m., an interview was conducted with the social service director regarding the grievance process. She explained that the old system used paper forms, which were submitted to department heads, investigated, and returned with a resolution. She stated the new system, implemented April 1st, was online and required scanning QR code with a cell phone to submit concerns. She stated staff could also key grievances into the system if residents reported them verbally. She acknowledged OR codes were intended for, survey questions, and required a cell phone to use. She stated the grievance process had been discussed with department heads and at resident council, but no evidence was provided of that education. The social worker reported that the administrator was the grievance officer and stated there was a posting in the hallway; however, when she walked to the hallway during the interview, no grievance officer posting was present. On 8/27/25, a review of a facility document titled, Resident and Family Grievance Policy. The policy stated residents and family members may voice grievances, and that the facility, will make prompt efforts to resolve grievances. The policy further stated: grievance official is responsible for overseeing the grievance process; notices of resident rights regarding grievances will be posted in prominent locations throughout the facility; residents and families may file grievances verbally, in writing, or anonymously; and contact information for the grievance official, including name, business address, mailing and email address, and phone number, will be available and posted in the facility. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/25, an end of day meeting was conducted with the administrator, director of nursing, and corporate staff. During the meeting they were made aware of the above concerns. No additional information was provided. 2. The facility did not implement an accurate grievance procedure for Resident #30 (R30). Diagnoses for R30 included degenerative disease of nervous system, carpel tunnel syndrome, muscle weakness, osteoarthritis, arthritis left shoulder and unsteady on feet. The most recent MDS was a quarterly assessment dated [DATE], assessed R30 as cognitively intact. Review of a grievance (written out by the administrator) dated 6/18/25 regarding an incident during a transfer to the bathroom by certified nurse assistant (CNA #4) for R30, indicated CNA #4 was rushed causing R30 to lose balance and hit her shoulder on the wall. The grievance documented that the director of nursing (DON) was aware of the incident had spoken to and provided education to CNA #4. On 8/27/25 at 4:30 p.m. during an end of day meeting, the director of nursing (DON) verbalized, being unaware of the incident until it was brought to her attention on 8/27/25. The DON verbalized being on vacation the week of the incident and did not educate CNA #4 as CNA #4 is an agency CNA and has not worked at the facility since the incident. The administrator verbalized that he thought the DON knew about the incident. The facilities Resident and Family Grievance Policy read in part, The Grievance Official will take steps to resolve the grievance, and record information about the grievance, and those actions [.]. No other information was presented prior to the exit on 8/28/25.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interviews, facility documentation the facility staff failed to implement their abuse policy for prescreening potential employees for five of 25 records reviewed. The findings included:The facility failed to follow its abuse prevention and background check policies as evidenced by not obtaining reference checks for two employees, not completing registry checks for two employees, and hiring an employee with a felony barrier crime. On 8-27-25, an employee record review was conducted. During the review, it was identified that one employee had no reference checks completed, and another had two reference checks that were not completed. Two nurses had findings noted on their licenses, but the facility did not obtain information about those findings. Additionally, one dietary employee disclosed a felony barrier crime on his sworn statement, which was confirmed on his background check, and the facility hired him.On 8-27-25, the Business Office Assistant was interviewed regarding background checks and license verification. She stated background checks are completed to ensure there are no barrier crimes, and the sworn statement provides information and permission to conduct the background check. She explained that license verification involves ensuring the license is current, and if anything is noted on the license, she provides it to the Administrator and Director of Nursing to determine whether the individual can be hired. She stated a barrier crime is identified on the criminal background check, and if it is non-nursing and occurred more than seven years ago, the Administrator can sign off to allow the hire. She added that if the license verification shows ?yes,' she prints that page but does not access the detailed information.On 8-27-25, the Director of Nursing stated she expected the Human Resource staff to bring her the employee file if a license verification indicated yes, so she could review what was on the license. The Director of Nursing stated she had not been provided with any files to review.On 8-28-25, the Administrator provided his employee file for review. After reviewing the file, he was questioned about the lack of reference checks. The Administrator stated that he had given two references for the corporate office to call and acknowledged that they were not in the file. He stated he had text messages, if that would count, and that he would get in touch with the corporate office to see if they had the references. No additional information regarding reference checks for the Administrator was provided.On 8/28/25, A facility document titled, Abuse, Neglect, and Exploitation Prevention and Reporting, was provided. This policy states that no employee or otherwise engaged individual may be employed if they: 3. (a) have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law; (b) have had a finding entered into the State Nurse Aide Registry concerning abuse, neglect, exploitation, mistreatment of residents, or misappropriation of property; or (c) have a disciplinary action in effect against their professional license by a state licensure body as a result of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of property. The policy further requires that background, reference, and credential checks be conducted on employees prior to or at the time of employment in accordance with applicable state and federal regulations. In addition, any person having knowledge that an employee's license or certification is in question should report such information to the Administrator.On 8/28/25, A facility document titled, Hiring Policy, was reviewed. The policy states that all applicants who receive a conditional offer of employment must undergo a background check, including, but not limited to, the Virginia State Police and the Virginia Department of Health Professions. All applicants must also have reference checks conducted, with a minimum of two reference checks documented in the personnel file, which may be completed via written or phone request. Pre-employment checklists and documents have been established to ensure consistent pre-employment inquiries and capture of information. The policy requires that all pre-employment documents and processes be completed before an official offer of employment can be made.On 8/28/25, another interview was conducted with the Business Office Assistant. She stated that the employee who was hired with a felony barrier crime was going to be terminated and that, according to her regional manager, this employee should never have been (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hired.On 8/28/25, the Administrator, the Director of Nursing, and Corporate Staff were made aware of the findings above. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, staff interview, and facility documentation review, the facility staff failed to label and store medications appropriately in the one medication room and on one of two medication carts (pink hall cart). The findings included:On 8/26/25 at10:08 a.m., an observation/inspection was conducted of the medication storage room in the presence of licensed practical nurse #2 (LPN #2). Within the medication room storage cabinet with over-the-counter medications there was four full bottles of Oyster shell calcium 500 mg. Each bottle had 200 tabs each and all had an expiration date of 6/2025. Each bottle had a sticker that read [pharmacy name redacted] nurse consulting-medication expiring soon, please review. There were also two bottles of fiber laxative, each bottle had 90 capsules and were noted to have had an expiration date of 7/25. The medication storage refrigerator had an internal thermometer that was reading 26 degrees Fahrenheit. The nurse confirmed that this temperature would freeze the medications and immunizations contained in the fridge and was going to adjust the temperature gauge of the fridge. However, the thermometer was noted to have been cracked, and it was uncertain if it was accurate. According to the temperature log, it had been checked by the third shift nurse and was noted at 12:01 a.m., to have a temperature recorded of 38 degrees. LPN #1 was asked about the expiration date of medications and stated that if they have expired, they may lose their effectiveness. On 8/26/25 at 10:28 a.m., an inspection was conducted of one of the two medication carts. Licensed practical nurse #2 (LPN #2) was present during the inspection and confirmed that the cart being inspected was the pink hall cart. Within the medication cart was a vial of lidocaine hcl 1% that had been accessed and had no open date. LPN #2 said she knows it was opened last Tuesday but stated she was not the nurse that opened it. LPN #2 said it is important to date vial(s) when opened so that you know how long it is good for. LPN #2 said, I'm going to get rid of this because she is off of it now. Within the drawer that contained over-the-counter medications, a bottle of fiber laxative capsules was available for administration and had an expiration date of 7/25. LPN #2 confirmed the capsules were expired and stated, it was an infection control issue giving expired medications. When asked who is responsible to check dates of medications, LPN #2 said everyone is responsible to check as you go. On 8/26/25 at 3:30 p.m., an interview was conducted with the facility's director of nursing (DON). When asked about medication storage she explained that her medical records employee does the ordering of supplies and should be checking the dates of items in the medication storage room at least weekly. She stated that the nurses should be looking at medications in the medication carts daily. When asked about multi-use vials, the DON stated they should be labeled on the box and vial with the date opened, so that expiration dates can be determined. The facility policy titled, Medication Labeling and Storage, was reviewed. The policy read in part, . 3. If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Medication Labeling: . 4. For over the counter (OTC) medications in bulk containers the label contains: a. the medication name, b. strength, c. quantity, d. accessory instructions, e. lot number, f. expiration date. 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 30 days unless the manufacturer specifies a shorter or longer date for the open vial. According to an additional facility policy titled, Medication Storage: Storage of Medication, which read in part, . 14. Outdated, contaminated, discontinued, or deteriorated medications are those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy, if a current order exists. On the afternoon of 8/26/25, the facility's administrator and director of nursing were made aware of the above findings.No additional information was provided.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview and facility documentation review, the facility staff failed to store and prepare food in a sanitary manner in the main kitchen and the unit pantry, having the potential to affect many residents residing on one of one unit.The findings included:On 8/26/25 at 8:35 a.m., a tour and observations in the main kitchen was conducted in the presence of the dietary manager (DM). The dietary manager was asked about his expectation regarding the labeling of opened food items and showed the surveyor write-on labels that have the prepared date and use by date. The DM stated he is more concerned about the use by date being present. When asked what the importance of labeling food items was, the DM said, So you know what is fresh and what's not, so you don't kill somebody. Food can be dangerous. Observations of the walk-in freezer revealed there was a bag of opened meat balls that was wrapped in saran wrap that had no date of when it was opened or to be used by. There was also a bag of food items that the dietary manager identified as manicotti that had no dates to indicate when it was opened or to be used by. Observations in the dry storage room revealed a bag of opened spaghetti noodles that was wrapped in saran wrap. No date could be seen as to when it was opened, the dietary manager unwrapped the noodles and stated that he tore it [the date] off. Also observed was a bag of elbow macaroni that had no date. There was a bag of opened five pound bag of sweet cornbread muffin mix that was opened, handwritten on the bag was a date of 8/9, the dietary manager was unable to determine if it was an open or use by date. Observations of the stand-alone cooler revealed two bowls of items that were not labeled with the contents, prepared date or date to be used. The dietary manager identified the items as sliced tomatoes and banana cream pie. There was also a half of a cucumber that had part of the skin removed and was wrapped in saran wrap and had no date of when cut or to be used by. There was also a staff member's personal mountain dew bottle that had been opened but had no dates. The dietary manager said, That has no business being in there. At the food preparation table in the kitchen, there were bulk food containers. There was two bulk containers of food thickener that had an open date of 7/25 and a use by date of 1/25. The dietary manager was unable to explain the dates if it was July 2025 and January 2025 or July 25, 2025, and January 25, 2026. There were two bags of opened powdered sugar that had been opened, one had an open date of 6/26 and use by 7/26, that the dietary manager explained the dates were month and year [June 2026/July 2026]. The second bag of powdered sugar had no dates. There was a bag of brown gravy powder mix that had an open date of 5/4 and no use by date was noted. An opened bag of brown sugar had a handwritten use by date of 9/20. Following the above observations a discussion was held with the dietary manager who confirmed it was confusing and left a lot to interpretation with the dates observed on items. You were unable to know if it was an open or use by date, if the dates were noted as month and day or month and year. On 8/26/25 at 9:12 a.m., an observation was conducted in the pantry on the unit. In the cabinets where dry foods and snacks for residents were stored it was noted that a bag of hot dog buns was present and had a best by date of 8/20/25. There was also a bowl of corn flakes cereal that the label read, CF [corn flakes] 8/15; UB [use by] 8/23. On 8/26/25 at 10:45 a.m., the dietary manager was observed coming out of the pantry on the unit. He was asked to accompany the surveyor back into the pantry and was shown the expired hot dog buns and corn flakes that were beyond their use by date. He removed both items and said he didn't know where the hotdog buns had come from. A review of the facility policy titled, Dietary Departments Standard Operating Policies and Procedures/ Cost Containment-Food Storage: General with an effective date of 12/2017, was conducted. The policy read in part, . 6. All foods that have been opened and partially used shall be dated and sealed before returning to a storage area. The facility policy titled, Food Storage: Covering, Labeling, Dating Food, was reviewed. According to the policy, 1. All foods are to be dated upon receipt. The date label shall reflect when the food has been received. The date upon receipt should be (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recorded as dd/mm/yy. 2. Follow manufacturer expiration dates or ?use by dates', when available to determine when a food should be discarded. Once a food item has been opened, use by dates may not apply. 4. All food items that are not stored in their original containers must be stored in closed containers, secured and labeled. The label must identify the common name of the food if the food cannot be easily identified. The label must have the date the food was packaged or prepared and/or the expiration date. Expiration dates may be used, or the food storage chart guideline may be used to determine the expiration date. 5. When storing bulk foods, such as cereal, pre-packaged cookies, and condiments, store in plastic containers with tight fitting lids. All bins must be labeled and dated as in #4. 6. When removing a food from dry storage, check the date label and discard any food that has passed the expiration dates or use by dates or storage guideline dates. The policy regarding covering, labeling and dating of foods, went on to read, Refrigeration Storage, 1. All foods must be covered, labeled and dated with a date label. All food should be monitored each day to be assured that the foods will be used, consumed or discarded by the use by date or expired date. On 8/26/25 at 2:55 p.m., the facility administrator was made aware of the above findings. No additional information was provided.

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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. Based on observations, resident interview, staff interview, clinical record review, facility documentation reviews the facility staff failed to review and revise comprehensive centered care plans for two residents, Resident #10 (R10) and Resident #36 (R36) out of a survey sample of 19 residents. The findings included: 1.The facility failed to update R10's comprehensive care plan to reflect his current condition. The care plan continued to identify a Stage 4 pressure injury after the wound had healed and was no longer present.On 8/26/25 at 3:28 p.m., an interview was conducted with R10. The resident stated that he did not have any open wounds and that previous wounds had healed. On 8/27/25 at 9:00 a.m., an interview was conducted with the director of nursing (DON). The DON confirmed that the resident's wound was healed and acknowledged that the care plan was incorrect. The DON stated her expectation was for staff to revise care plans to reflect current conditions.On 8/27/25, a clinical record review of R10's was conducted. The care plan, revised on 5/9/25, indicated that he had a Stage 4 pressure ulcer. The Minimum Data Set (MDS), completed on 6/18/25, documented that he had no pressure wounds. According to the clinical record, the wound healed in March 2025.On 8/27/25, an end of day meeting was conducted with the administrator, director of nursing, and corporate staff. During the meeting they were made aware of the above concerns.2.R36's comprehensive care plan did not reflect the use of assistive devices during meals.On 8/27/25 at 8:15 a.m., an observation was made of R36's lunch meal. R36 liquids were not provided in coffee mugs according to his meal ticket. He was observed to have difficulty picking up the glass of milk. On 8/27/25 at 9:20 a.m., an interview was conducted with R36 regarding his difficulty picking up the glass of milk. He stated, yes, need handles.On 8/27/25, a clinical record review was conducted for R36. The record contained a physician's order dated 8/26/25 for all drinks to be provided in coffee mugs. During the review it was noted that his comprehensive care plan did not reflect the use of assistive devices with meals, coffee mugs, to support his strengths and ability to consume liquids safely.On 8/28/25 a facility document titled, Care Plans Comprehensive Person Centered, was reviewed. The policy states that a comprehensive, person-centered care plan includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs and is developed and implemented for each resident. 7. e. the policy specifies that care plans should reflect currently recognized standards of practice for problem areas and conditions. Under number 11, the policy stated that assessments of residents are ongoing, and care plans are revised as information about the resident and the resident's condition changes.On 8/28/25 at 11:30 a.m., the administrator, director of nursing, corporate staff were made aware of the above concerns.No additional information was provided.

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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. **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 follow physician orders for two of nineteen residents in the survey sample (Residents #17 and #46).The findings include:1. For Resident #17, staff failed to accurately monitor fluid intake to ensure compliance with a physician ordered fluid restriction. Resident #17 (R17) was admitted to the facility with diagnoses that included end stage renal disease, metabolic encephalopathy, glaucoma, epilepsy, dysphagia, anemia and diabetes. The minimum data set (MDS) dated [DATE] assessed R17 with moderately impaired cognitive skills. R17's clinical record documented a physician's order dated 8/14/25 for a fluid restriction of 1500 ml (milliliters) per day due to end stage renal disease with instructions for 4 ounces (oz.) of fluid to be administered four times per day with medication administration and the remaining ounces served on the meal tray. On 8/26/225 at 11:32 a.m., R17 was observed in bed. There was a tall thermal mug, shorter thermal mug and two coffee mugs on the resident's over-bed table. R17 was interviewed at this time about the fluid restriction and the mugs observed on the bedside. R17 stated she did not know how staff tracked her fluid intake. R17 stated the tall and short mugs on her table had water in them and the coffee mugs had tea from her meal trays. R17's medication administration record for August 2025 documented 2 oz. to 4 oz. of fluid was administered four times per day with each medication administration as ordered. Intake records documented fluid intake with each meal ranging from 120 ml and 600 ml. There was no documentation in the clinical record regarding any other fluid intake and no daily summary reflecting the resident's total fluid intake each day. On 8/27/25 at 2:56 p.m., the licensed practical nurse (LPN #4) caring for R17 was interviewed about the fluid restriction. LPN #4 stated the 4 oz. ordered at each medication administration was documented on the medication administration record. Accompanied by LPN #4, R17's mugs/cups were observed on the over-bed table. R17 stated at this time that the girls filled her tall and short mug with water and that I drink when I want. LPN #4 stated the certified nurse's aides were supposed to enter fluid intakes from meals, but she was not sure if fluid intake between meals was tracked. On 8/27/25 at 3:05 p.m., the certified nurse's aide (CNA #1) caring for R17 was interviewed. CNA #1 stated she was not aware R17 was on a fluid restriction. CNA #1 stated she routinely filled the brown mug each shift as the resident requested. CNA #1 stated one beverage was usually provided on each meal tray. CNA #1 stated she entered the meal tray intake but did not enter fluid intake between meals. CNA #1 stated, I've never been told to keep up with her [R17's] intake. CNA #1 stated for residents on fluid restriction, all fluid intake was usually recorded. On 8/27/25 at 3:32 p.m., the director of nursing (DON) was interviewed about compliance with R17's ordered fluid restriction. The DON stated the physician ordered fluid restriction should have been included on the R17's bedside Kardex that CNAs referenced for care instructions. The DON reviewed R17's Kardex (dated 8/27/25) and stated she did not see the fluid restriction listed on the Kardex. The DON stated the resident's supplemental fluid intake should have been monitored in addition to fluids provided on the meal tray and medication pass. The DON stated she reviewed fluid intakes for (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Hall Lexington	205 Houston Street East Lexington, VA 24450

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	those residents with restrictions but that R17's between meal intakes had not been monitored or included in the totals each day. This finding was reviewed with the administrator, director of nursing, assistant director of nursing and regional nurse consultant during a meeting on 8/27/25 at 4:30 p.m. with no further information provided prior to the end of the survey. 2. Resident #46 did not receive a bariatric bed as ordered by the physician. Diagnoses for Resident #46 (R46) included: respiratory failure, anxiety, COPD, severe morbid obesity, and fibromyalgia. The most recent MDS (Minimum Data Set) was a quarterly dated 7/23/25, R46's BIMS score was 14, indicating cognitively intact. On 8/26/25 at 10:21 a.m. R46 was interviewed. R46 verbalized that the facility had ordered a Bariatric bed a month ago or so and has not gotten the bed yet. R46 expressed that the current bed is uncomfortable and the controls along with trying to reach things on the bedside table are difficult. Review of R46 physician's orders documented an order (dated 6/10/25) that read Bariatric Bed. Review of R46's care plan indicated a Bariatric bed was in place. On 8/28/25 at 11:00 a.m. the director of nursing (DON) and nurse consultant observed R46's bed. The DON said that the bed R46 was currently in was not a Bariatric bed and would look into the concern. On 8/28/25 at 11:30 a.m. The DON verbalized that she was unsure if the bed had been ordered and was unaware of the physician's order for the bed. The DON said that the facility has a Bariatric bed, but if it was in use then the supply clerk would order a bed. The DON said that the supply clerk was not at the facility currently and was unable to be reached. The DON said R46 did not want a Bariatric bed at this time but expressed understanding regarding the physician order had been in place since June 2025. No other information was provided prior to the exit conference on 8/28/25.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and clinical record review, the facility failed to notify and thoroughly investigate an incident during toileting for one of nineteen resident's, Resident #30 (R30).The findings include: Diagnoses for R30 included degenerative disease of nervous system, carpel tunnel syndrome, muscle weakness, osteoarthritis, arthritis left shoulder and unsteady on feet. The most recent MDS was a quarterly assessment dated [DATE], assessed R30 as cognitively intact. Section GG indicates R30 needs supervision for toileting, partial to moderate assistance for sit to stand. A 6/4/25 MDS indicates partial to moderate assistance in lower body dressing, and partial to moderate for sit to stand and supervision or touching for toilet transfer. On 8/26/2025 at 1:51 p.m. R30 was interviewed. During the interview R30 verbalized falling about a month prior while being helped to the bathroom by a certified nursing assistant (CNA). R30 said that the CNA (identified as CNA #4) was asking R30 to pull up her pants while CNA #4 was supporting R30. R30 verbalized that she had lost her balance and fell against the wall and then sat down on the commode. R30 said her shoulder started hurting the next day.Review of R30 clinical record did not evidence any progress notes or assessments by the nursing staff on 6/17/25.Review of a progress note dated 6/18/25 by the nurse practitioner read in part in part The patient reports onset of right shoulder pain after a transfer incident yesterday afternoon/evening. A CNA assisted her to the bathroom, during which she had difficulty with the transfer and hit her right shoulder against the wall. She denies falling during the incident. Since then, she has experienced mild soreness in the right shoulder, which persists today. The pain is not severe and is only mildly noticeable when the shoulder is in extension with the arm overhead. Several weeks ago, she experienced left shoulder pain, which was effectively managed with Tylenol and lidocaine. She is currently working with physical therapy. On 8/27/25 the administrator was asked to see any incident reports related to R30's incident on 6/17/25.On 8/27/25 at 1:15 p.m. the director of nursing (DON) verbalized, being unaware of the incident until it was brought to her attention on 8/27/25. The DON verbalized being on vacation the week of the incident. The DON said that if an incident occurs it should be reported to the nurse on the floor and an incident report would have been filed. The DON presented a staff list of nurses and CNA's working on the day of the event and identified CNA #4 (agency CNA) assigned to R30 on the day and time frame of R30's incident.An interview was conducted on 8/27/25 with two CNA's (2 and #3) that are assigned to R30 consistently. Both CNAs were not aware of any incident regarding R30 on 6/17/25. Both CNAs expressed that R30 needed help pulling down and up her pants after using the bathroom and they would do this task while R30 supported herself using the grab-bar in the bathroom. License practical nurse (LPN #5), and registered nurses (RN #1 and RN #2) were working the day of the incident. Were contacted via telephone and all verbalized being unaware of an incident regarding R30.On 8/27/25 at 3:50 p.m. the nurse practitioner (other staff, OS #3) was interviewed. OS #3 verbalized while in R30's room on 6/18/25 working with R30's roommate, R30 verbalized that her shoulder was hurting and explained that during a transfer to the toilet R30 had lost balance and hit her shoulder against the wall. OS #3 explained that R30 was assessed at this time and did not find anything abnormal but did have some pain when moving her arm. OS #3 said R30 did have a diagnosis of arthritis and felt that the hit to the shoulder could have set off some pain and soreness to the area. OS #3 said that when R30's pain became persistent an x-ray was completed and showed no fracture or concerns, R30 was also ordered therapy to help with pain and mobility. When asked about notifying nursing staff regarding what was reported to her by R30, OS #3 verbalized, she thought the staff already knew about the incident. On 8/27/25 at 4:30 p.m. during an end of the day meeting with the facility staff the above information was presented. At this time the administrator verbalized that a grievance was completed on 6/18/25 regarding this incident and presented the grievance. The grievance indicated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that R30 told her daughter (who works at the facility as a human resource manager, OS #4) about the incident and described the incident as CNA #4 was rushing with R30's toileting. On 8/27/25 at 5:00 p.m. OS #4 was interviewed. OS #4 verbalized being R30's daughter and had checked on R30 on 6/18/25. OS #4 said that R30 expressed that she (R30) felt the aide was rushing to help R30 in the bathroom and R30 hit her shoulder on the bathroom wall. OS #4 said that she filed a grievance with the administrator and asked that CNA #4 no longer be assigned to her mother. OS #4 said that R30 does try to do things herself and feels that R30 sometimes doesn't know her inability. Attempts were made to contact CNA #4 but were unsuccessful.No other information was presented prior to the exit on 8/28/25.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, resident interview, staff interview, clinical record review, facility documentation the facility staff failed to administer oxygen per physician's orders for one resident, Resident #1 (R1) out of a survey sample of 19 residents. The findings included:The facility was not following physician's orders for R1's oxygen therapy.8/26/25 at 9:00 a.m., an observation was made of R 1's oxygen set at 8.5 liters. On 8/27/25, an observation in the morning showed her oxygen was set at 9 liters. Later in the afternoon of 8/27/25, her oxygen was observed to be set at 10 liters. 8/27/25 at 9:00 a.m., an interview was conducted with R1 about her oxygen therapy. When asked about her oxygen she said, it too much I think sometimes. They put that thing on my finger and then turn the knobs.08/27/2025 9:12 a.m., R1's oxygen was observed to be set to 9 liters per minute. An interview was conducted with licensed practical nurse, LPN#6 (LPN6). LPN6 stated if R1's saturation levels fell below 88%, the oxygen may be increased to 10 liters per minute. She reported that R1's oxygen saturation level was checked at 5:00 a.m., that morning and was 97%. LPN6 verified that R1's oxygen was not set correctly and should be at 8 liters per minute. She then checked the oxygen saturation again, and it was 94. On 8/27/25, a review of R1's clinical record was conducted. R1's care plan reflected that oxygen should be administered at 8 liters per minute via high-flow nasal cannula to maintain oxygen saturations at 88%. It also included instructions to check pulse oximetry every four hours and stated that if saturations fell below 88%, oxygen could be increased to 10 liters per minute until saturations were above 90%. R1 had physician orders that were written on 7/24/25 to be administered at 8 liters per minute via high-flow nasal cannula to maintain oxygen saturations at 88% and check pulse oximetry every four hours and stated that if saturations fell below 88%, oxygen could be increased to 10 liters per minute until saturations were above 90%.On 8/27/25, facility documentation titled, Oxygen Administration, was reviewed. The policy states that the purpose of this procedure is to provide guidelines for safe oxygen administration. It instructs staff to verify that a physician's order is in place, review the physician's order or facility protocol for oxygen administration, review the resident's care plan to assess any special needs, and assemble the necessary equipment and supplies prior to administering oxygen. On 8/27/25, an end of day meeting was conducted with the administrator, director of nursing, and corporate staff. During the meeting they were made aware of the above concerns.No additional information was provided.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to document response to a pharmacy recommendation for one of nineteen residents in the survey sample (Resident #23).The findings include:Resident #23 (R23) was admitted to the facility with diagnoses that included Parkinson's disease, diabetes, chronic kidney disease, atrial fibrillation, dementia, obstructive sleep apnea, diabetes, major depressive disorder, anxiety, dysphagia, cognitive communication deficit, hypertension and gastroesophageal reflux disease. The minimum data set (MDS) dated [DATE] assessed R23 with short and long-term memory problems and severely impaired cognitive skills.R23's clinical record documented a physician's order dated 12/9/24 for trazodone 25 milligrams each afternoon for agitation. R23's medication administration records for December (2024) and January (2025) documented the trazodone was administered each day at 5:00 p.m. R23's clinical record documented a pharmacy recommendation dated 1/2/25 regarding the trazodone. The recommendation documented, .This resident has a medication that has a side effect of increased sedation. The trazodone order is being administered at 5 PM daily. This increased sedation could lead to a fall. Recommend to monitor carefully and consider changing the time to bedtime unless clinically contraindicated.A hand-written note by the assistant director of nursing (ADON) dated 1/8/25 was documented on the recommendation sheet stating, .Given specifically @ 1700 [5:00 p.m.] for agitation. See MD [physician's] note 12/9/24 . The clinical record documented no physician response to the recommendation to change the trazodone administration time to bedtime. The nurse practitioner (NP) assessed R23 on 1/3/25 and 1/15/24 and made no mention or reference to the pharmacy recommendation.On 8/27/25 at 1:38 p.m., the ADON (LPN #3) was interviewed about a response to R23's pharmacy recommendation on 1/2/25. The ADON stated she would have reported the recommendation to the NP. When asked about the reference to the NP note that was made prior to the recommendation, the ADON stated if she wrote that note (1/8/25), she would have asked the NP, and the NP responded that she already addressed it in the 12/9/24 note. On 8/27/25 at 2:15 p.m., the director of nursing (DON) was interviewed about a documented response to the 1/2/25 pharmacy recommendation. The DON stated recommendations designated for the providers were routinely sent to them for response. The DON stated the ADON routinely handled the recommendations including getting responses to recommendations as required. The DON stated nursing should have contacted/notified the provider for clarification and documented if the recommendation was wanted or denied.8/27/25 at 3:56 p.m., the nurse practitioner (NP - other staff #3) caring for R23 was interviewed about the trazodone recommendation. The NP stated the trazodone was prescribed at 5:00 p.m. because the resident's agitation increased around that time each day. The NP stated she remembered a conversation about wanting the administration time to stay at 5:00 p.m. but she did not know if anything was documented specifically about the recommendation.The facility's policy titled Medication Regimen Review and Reporting (dated 1/2024) documented, .Resident-specific MRR [medication regimen review] recommendations and findings are documented and acted upon by the nursing care center and/or physician .For those issues that require physician intervention, the attending physician either accepts and acts upon the report and recommendations or rejects all or some of the report and should document his or her rationale of why the recommendation is rejected in the resident's medical record .This finding was reviewed with the administrator, director of nursing, assistant director of nursing and regional nurse consultant during a meeting on 8/27/25 at 4:30 p.m. with no further information presented prior to the end of the survey.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interview, clinical record review, facility documentation reviews the facility staff failed to obtain labs per physician orders for one resident, Resident #9 (R9) out of a survey sample of 19 residents. The findings included:The facility did not obtain R9's lab the day it was ordered.On 8/28/25, an interview was conducted with the director of nursing (DON) regarding R9's lab work. The labs were scheduled to be completed on 8/25/25. The DON stated that, unfortunately, the lab scheduled for 8/25/25 was not obtained that day and there were no results available. The responsible person and physician were notified, and the lab was obtained today.On 8/28/25, a clinical record review was conducted for R9. The review revealed a physician's order dated 8/25/25 to obtain a PT-INR (pro-time/international normalized ratio). The resident's care plan included a directive to obtain labs as ordered.On 8/28/25, facility documentation titled Lab and Diagnostic Test Results was reviewed. The policy states that the physician will identify and order diagnostic and lab testing based on the resident's diagnostic and monitoring needs. Staff are responsible for processing test requisitions and arranging for tests. The laboratory, diagnostic radiology provider, and other testing sources are required to report test results to the facility. The physician may be notified by phone, fax, voicemail, email, mail, pager, or telephone message to another person acting as the physician's agent. Facility staff are instructed to document when, how, and to whom the information was provided in the residents record.On 8/27/25, an end of day meeting was conducted with the administrator, director of nursing, and corporate staff. During the meeting they were made aware of the above concerns.No additional information was provided.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, resident interview, staff interview, facility documentation review, clinical record review, the facility staff failed to provide therapeutic diet per physician's orders for one resident, Resident #36 (R36) out of a survey sample of 19 residents. The findings included:R36's meat was not served moistened with gravy or sauce per physician orders.On 8/27/25 at 8:56 a.m., R36 was observed during the breakfast meal. His sausage was served without gravy or sauce and appeared dry. His meal ticket read: Regular, Mechanical Soft, Ground Meats, and ground meat with gravy. On 8/27/25, R36 was interviewed and repeatedly pointed at the sausage, saying no, no. His responsible person was also interviewed and stated that the only issue she had with the facility was the food, explaining that he does not eat well, the meals need to be more resident-centered, and the meats are dry, which he does not like.On 8/27/25, an interview was conducted with a certified nursing assistant, CNA #6 (CNA6). She was unsure about the gravy but acknowledged that if it is listed on the ticket, it should be provided. On 8/27/25, an interview with the Dietary Manager revealed that when the ticket specifies meat with gravy, it means the meat should be moistened. He stated that while sausage is naturally moist from grease, the ticket specifically said gravy or sauce, so it should have been served that way. He also stated meal tickets should be followed as they are based on physician orders.On 8/27/25, a clinical record review was conducted for R-36. His physician's orders included a mechanical soft diet with meats served with gravy or sauce and all drinks to be served in coffee mugs with meals. Review of his comprehensive care plan also reflected a therapeutic diet of mechanical soft with gravy or sauce on meats.On 8-27-25, an end-of-day meeting was held with the Director of Nursing, the Administrator, and corporate staff. They were made aware of the above concerns, and no additional information was provided.No additional information was provided.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, resident interview, staff interview, clinical record review the facility staff failed to provide assistive devices with meals for one resident, Resident #36 (R36) out of a survey sample of 19 residents.R36's drinks was not in coffee mugs with his meals.On 8/27/25, R36 was observed during the breakfast meal. He did not have his fluids served in coffee mugs. His meal ticket read: Regular, Mechanical Soft, Ground Meats, Coffee mugs - put drinks in coffee mugs, and ground meat should have gravy on the meat. On 8/27/25, an interview was conducted with R36 regarding his difficulty picking up the glass of milk. He stated, yes, need handles.On 8/27/25, an interview was conducted with a certified nursing assistant, CNA #6 (CNA6). She stated that if the meal ticket indicates drinks in coffee mugs, then they should be served that way. On 8/27/25, R36 was interviewed and repeatedly pointed at the sausage, saying no, no. His responsible person was also interviewed and stated that the only issue she had with the facility was the food, explaining that he does not eat well, the meals need to be more resident-centered, and the meats are dry, which he does not like. An interview with the Dietary Manager revealed that when the ticket says all drinks are in coffee mugs, they must be served in coffee mugs, and tickets should be followed as they are based on physician orders.On 8/27/25, a clinical record review was conducted for R-36. His physician's orders included a mechanical soft diet with meats served with gravy or sauce and all drinks to be served in coffee mugs with meals. Review of his comprehensive care plan did not reflect to have all drinks served in coffee mugs with R36's meals.On 8-27-25, an end-of-day meeting was held with the Director of Nursing, the Administrator, and corporate staff. They were made aware of the above concerns, and no additional information was provided.No additional information was provided.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview and facility document review, the facility staff failed to follow infection control practices for hand hygiene on one of four units (Sunset Drive).The findings include:A medication pass observation was conducted on 8/27/25 at 8:00 a.m. with licensed practical nurse (LPN #4) administering medications to Residents #42 and #2. After preparing and administering medication to R42, LPN #4 washed her hands at the room sink. After washing hands, LPN #4 directly touched the faucet handle to turn off the water, prior to drying her hands on with a paper towel. LPN #4 then prepared and administered medications to Resident #2. On 8/27/25 at 8:11 a.m., LPN #4 was interviewed about directly touching the faucet handle after hand washing. LPN #4 stated, I was probably nervous.On 8/27/25 at 8:34 a.m., the director of nursing (DON) and infection preventionist was interviewed about the observed hand washing. The DON stated after washing hands for approximately 20 seconds, hands should be rinsed, dried and the water turned off with use of a dry paper towel. The DON stated nurses were not supposed to directly contact the faucet handles after washing hands.The facility's policy titled Handwashing/Hand Hygiene (revised August 2019) documented, .This facility considers hand hygiene the primary means to prevent the spread of infections .All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors . This policy listed the procedure for handwashing as, .Wet hands first with water, then apply an amount of product .Rub hands together vigorously for at least 20 seconds .Rinse hands with water and dry thoroughly with a disposable towel .use towel to turn off the faucet .This finding was reviewed with the administrator, director of nursing, assistant director of nursing and regional nurse consultant during a meeting on 8/27/25 at 4:30 p.m. with no further information provided prior to the end of the survey.