State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	09/01/2016

NAME OF PROVIOER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard and biennial State Licensure Inspection was conducted 08/30/16 through 09/01/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four Complaints were investigated during the survey. The census in this 145 certified bed facility was 116 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through 20) and 7 closed record reviews (Residents #21 through 27). The survey sample consisted of 27 residents, 20 current Resident reviews (Resident #1 through 20) and 7 closed record reviews (Resident #21 through 27).	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5-371-300 (B) Pharmaceutical Services Please Cross Reference F 425 12 VAC 5-371-220 (H) Nursing Services Please Cross Reference to F-309	F 001	**F 001** **12 VAC 5-371-300 (B) Pharmaceutical Services** Cross Reference to F 425 Cross Reference POC for F 425 **12 VAC 5-371-220 (H) Nursing Services** Cross Reference to F 309 Cross Reference POC for F 309 **Completion Date: October 14, 2016** RECEIVED SEP 26 2016 VDH/OLC	10/14/16

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

Chad Dalton | Administrator | 9/22/16

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard was conducted 08/30/16 through 09/01/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Four Complaints were investigated during the survey. The census in this 145 certified bed facility was 116 at the time of the survey. The survey sample consisted of 20 current resident reviews (Residents #1 through 20) and 7 closed record reviews (Residents #21 through 27). The survey sample consisted of 27 residents, 20 current Resident reviews (Resident #1 through 20) and 7 closed record reviews (Resident #21 through 27).	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.	F 164	**F164** **Corrective Action:** LPN #2 performing the medication pass with Resident #16 was inserviced on the facility policy and procedure for providing privacy when performing insulin injections during the medication pass. A Facility Incident and Accident report was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents may have been potentially affected. A 100% observation audit of all nurses administering medications has been conducted to identify any residents at risk for the potential unnecessary exposure of their body parts during the medication pass. Any negative findings noted during the audit will be corrected at time of discovery. A Facility Incident & Accident Form will be completed for any/all medical information exposure during the medication pass.	10/19/16

VDH/OLC SEP 26 2016

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	9/22/16

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 t4 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 164	Continued From page 1 The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews and facility document review, the facility staff failed to provide privacy to prevent unnecessary exposure of body parts during medication administration for 1 of 27 residents in the survey sample, Resident #16. The findings included: Resident #16 was admitted to the facility on 8/4/16. Diagnosis for Resident #16 included but not limited to Diabetes Mellitus. The 14-day Minimum Data Set (an assessment protocol) with an assessment reference date of 8/16/16, coded Resident #16 as having the ability to complete the Brief Interview for Mental Status with a total score of 15 out of a possible 15, indicating the resident's cognition was intact. During the medication pass observation on 8/30/16 at 4:30 pm, LPN #2 (licensed practical nurse) administered Resident #16's insulin injection without closing the door and pulling the privacy curtain for resident privacy. LPN #2 exposed the resident's abdomen in public view	F 164	Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the DON, and/or Social Services director on Resident Rights, Confidentiality and Personal Privacy to include maintaining resident privacy during medication pass to prevent unnecessary body exposure during care and services. **Monitoring:** The DON is responsible for compliance. The DON and/or Unit Managers will perform two random weekly medication pass audits on each unit in order to maintain compliance. Any/all negative findings will be corrected immediately and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: October 14, 2016**	

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F 164	Continued From page 2 and in the presence of a family member. On 8/31/16 at 3:55 pm, the Director of Nursing (DON) provided a copy of the facility policy and procedure on "Quality of Life - Dignity"; Nursing Services Policy and Procedure Manual; 2001 MED-PASS, Inc. (revised October 2009), as requested. It is stated in the policy and procedure, "Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures". On 8/31/16 at 4:15 pm, Resident #16 was interviewed and was asked whether the nurse closed the door or pulled the privacy curtain when administering his insulin injection and he stated, "They don't close the door and pull the curtain". He added, "They close it during my bath". On 8/31/16 at 4:25 pm, RN (registered nurse) Unit Manager #1 was interviewed and was asked about her expectations during insulin administration by staff nurses and stated, "Pull the curtain, shut the door" On 8/31/16 at 4:35 pm, LPN #2 was interviewed and was asked about the facility policy and procedure for insulin administration and stated, "For bed A, shut the door and draw the curtain. For bed B, draw the curtain but per policy, shut the door for A and B". When reviewed with LPN #2 regarding failure to close the door and pull the privacy curtain during insulin administration on Resident #16 on 8/30/16 at 4:30 pm and she stated, "I did not do that. It will not happen again". The above findings was shared with the Administrator, the DON and the Clinical Services	F 164		

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F 164	Continued From page 3 Director during a pre-exit meeting conducted on 9/1/16 at 2:20 p.m. No additional information was provided prior to exit.	F 164	**F309** **Corrective Action(s):** Resident #19's attending physicians has been notified that the facility staff failed to notify the physician of a blood glucose level great than 401 5 times in the month of August. A Facility Incident & Accident Form and a medication error form were completed for these incidents.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined for Resident #19, one of 27 residents in the survey sample, that facility staff failed to assure the physician's order to be notified when the resident's blood sugar was over 401 milligrams per deciliter (mg/dl) was completed. The finding included: The resident's blood sugar level was documented on the MAR (medication administration recorded) as over 401 eight times in August 2016. Documentation evidenced the physician was contacted only three of the eight times. Resident #19 was admitted to the facility on 3/1/13 and at the time of the survey was 72 years old. Review of the annual 11/13/15 Minimum Data Set (MDS-an assessment protocol) and the	F 309	**Identification of Deficient Practices/Corrective Action(s):** All other residents with Blood Glucose monitoring orders may have been potentially affected. The DON, ADON and/or unit managers will conduct a 100% audit of all resident physician orders and MAR's to identify residents at risk. Residents identified at risk will have the attending physicians notified. A facility Incident & Accident Form & medication error for will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record & physician orders remains the source document for the development and monitoring of the provision of care. Which includes, obtaining, transcribing and administering physician medication orders & treatment orders as ordered by the physician. The DON and/or Regional nurse consultant will inservice all licensed staff on the procedure for obtaining, transcribing and completing physician medication & treatment orders. As well as the procedure for proper physician notification as ordered for medication administration of physician ordered medications and treatments.	10/14/16

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F 309	Continued From page 4 8/11/16 quarterly MDS evidenced the resident's cognition was a 6 of 15 and a 4 of 15 respectively indicating moderate impairment. The resident's functional status remained at the limited assistance of one person for bed mobility and transfer. Once up in a wheelchair the resident required the minimal assistance of one for locomotion on and off the unit. Review of the clinical record evidenced a physician's order for sliding scale insulin. Sliding scale (SS) insulin is administered following a blood sugar (BS) reading usually prior to a meal. Depending on the reading a prescribed amount of insulin units is administered, the higher the blood sugar reading the more insulin units ordered to be administered.. The resident's order was for Regular insulin with BS checks prior to meals at 7:30 am, 11:30 a.m., and 4:30 p.m. This order was discontinued on 8/24/16. The new SS insulin order was for Humalog Insulin started on 8/24/16. The morning BS check was for 6:00 am not 7:30 am. Both the Regular Insulin and Humalog Insulin had a top BS value of 401 to 450 mg/dl. The nursing staff was to administer 12 units of the ordered insulin and then to notify the physician. Review of the August 2016 MAR or Medication Administration Record evidenced eight times that Resident #12's BS was over 401, only three events were reported to the physician per his order to do so. The following dates and BS values were recorded on the MAR:	F 309	Monitoring: The DON will be responsible for maintaining compliance. The DON and/or designee will conduct weekly MAR audits of all resident with blood glucose monitoring in order to maintain compliance. Any/all negative findings and/or errors will be corrected at time of discovery, disciplinary action will be taken as needed and the attending physician notified of all negative findings. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: October 14, 2016	

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F 309	Continued From page 5 8/6/16, 4:30 pm BS 538, 8/7/16, 11:30 am BS 525, 8/8/16, 11:30 am BS 525, 8/9/16, 4:30 pm BS 478, 8/23/16 , 11:30 am BS 585, 8/24/16. 11:30 am BS 593, 8/25/16 11:30 am BS 476, 8/27/16 11:30 am BS 483. Review of the nursing note documentation evidenced of the above eight elevated BS meeting the physician ordered reportable levels, only three were reported to the physician. On 8/6/16, 8/7/16 and 8/23/16 the physician was documented (in the nursing notes) as being in the building and he was notified of the elevated BS. On 9/1/16 at approximately 11:30 am the DON (Director of Nurses) was notified of the lack of physician notification documentation., she was request to provide any additional information. At 1:13 pm, on 9/1/16 during an interview with the facility Administrator he stated, "we don't have anything else".	F 309		
F 371 SS=D	COMPLAINT DEFICIENCY 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	F 371 Corrective Action(s): The Food Service Manager has reviewed the Federal and State guidelines for preparing, storing, distributing food under sanitary conditions, as well as the policy and procedure for wearing of hair and beard nets while in the kitchen at all times. A facility Incident & Accident form has been completed for this incident.	10/14/16

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F 371	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, the kitchen staff failed to prepare food in a sanitary manner. During the facility survey, conducted from 8/30/16 through 09/01/16, multiple observations were made of the kitchen. On 8/30/16 at approximately 12:45 p.m. Kitchen Aide #4 was preparing ice tea glasses and was observed to not have a hair covering over his beard. The Dietary Manager was interviewed on 8/30/16 and asked if the aide should have a covering over his beard. The Dietary Manager stated, "Yes, he should, I'm sorry that I just missed it." The Food and Drug Administration website http://www.fda.gov/Food/GuidanceRegulation/RetailFoodProtection/FoodCode/ucm181242.htm#part2-3 documents: food employees shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. The facility administration was informed of the findings during a briefing on 9/1/16 at approximately 4:00 p.m. The facility did not present any further information about the findings.	F 371	Identification of Deficient Practices & Corrective Action(s): All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will review the kitchen preparation area and the cleaning of these areas during and after meals to include hair/beard net use to identify any negative findings. All negative findings will be corrected at time of discovery. A facility Incident & Accident form will be completed for each negative finding identified. All negative findings will result in appropriate disciplinary action. Systemic Change(s): Current facility policy & procedure has been reviewed and no changes are warranted at this time. The consulting Registered Dietician will inservice the CDM and dietary staff on the proper sanitation, storage, cleaning and transportation of dietary products per established policy and procedure. In addition the inservice will cover the procedure for proper hair/beard net application at all times while in the kitchen area. The inservice will include all aspects of infection & sanitation control measures. Monitoring: The CDM is responsible for maintaining compliance. The Administrator and/or Food service manager will complete the Dietary Audit Tool weekly for monitoring and maintaining compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: October 14, 2016	
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH	F 425		

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F 425	Continued From page 7 The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to implement pharmaceutical procedures for dispensing of expired biologicals and labeling of biologicals on 2 of 3 nursing units. The findings included: On 8/31/16 at 12:45 p.m., a medication room inspection was conducted on the right hall nursing unit. Stored inside the medication refrigerator were medications and biologicals to include several multi-dose vials of insulin. Four of the insulin multi-dose vials were expired as follows:	F 425	F425 Corrective Action(s): The expired insulin that was noted in the Left side and right side medication rooms was removed and disposed of and replacement insulin was obtained. A Facility Incident & Accident Report has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All other residents may have been potentially affected. The DON and/or designee will conduct a 100% review of all current medication rooms and medication carts to identify any expired or unlabeled medications. Any/all negative findings will be corrected at time of discovery. A Facility Incident & Accident Report will be completed for each incident identified. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. The licensed nursing staff will be inserviced by the regional nurse consultant and/or DON on the policy for monitoring medications to include, proper labeling, dating and removal of all expired medications to include all biologicals not labeled or dated when opened.	10/14/16

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F 425	Continued From page 8 1. Lantus 100 units/ml (milliliter); open date 7/6/16, expired on 8/3/16. 2. Humulin Regular 100 units/ml; open date 7/6/16, expired on 8/6/16. 3. Humalog 100 units/ml; open date 6/30/16, expired on 7/28/16. 4. Humalog 100 units/ml; open date 7/23/16, expired on 8/20/16. The right side hall Registered Nurse (RN) unit manager was in the medication room at this time. She was asked who is responsible for discarding outdated insulin, she stated, "I personally think everybody using the insulin should be checking." On 8/31/16 at 1:15 p.m., the left side nursing unit medication room was inspected. One multi-dose vial of Novolog insulin 100 units/ml was dated as opened on 8/2/16, expired on 8/30/16. One opened multi-dose vial of Humalog 100 units/ml insulin was not labeled when opened. The left side hall RN unit manager accompanied the inspectors during the medication room inspection. She stated her expectation is that every nurse should be checking the dates opened on the insulin vials prior to use. Review of the facility's pharmacy guidelines titled 'Insulin Storage Recommendations' posted on the medication refrigerators revised 3/31/16 read, in part: Opened refrigerated Humalog, Lantus and Novolog insulin vials expire 28 days after opening. Opened refrigerated Humulin Regular insulin vials expire 31 days after opening. The above findings was shared with the Administrator, the Director of Nursing and the Clinical Services Director during a pre-exit	F 425	**Monitoring:** The DON is responsible for maintaining compliance. The DON, and/or designee will perform weekly audits of all medication carts and the medication rooms to ensure that medications are being labeled and dated appropriately and that all expired medications are being removed per protocol. Detail findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: October 14, 2016**	

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F 425	Continued From page 9 meeting conducted on 9/1/16 at 2:20 p.m. No additional information was provided prior to exit.	F 425		