STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/17/17 through 10/19/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 58 at the time of the survey. The survey sample consisted of 18 current Resident reviews (Residents 1 through 12) and 6 closed record reviews (Residents 13 through 18).	F 000		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review it was determined that the facility staff failed to provided effective housekeeping services with regard to bed coverings for 2 of 18 residents in the survey sample Resident #4 and Resident #5. The findings include: 1. Resident #4 was originally admitted to the facility on 1/25/11 with 8/2/17 listed as a date of readmission. Diagnosis include but not limited to Dementia, Hypertension, Major Depressive Disorder, Osteoarthritis, and Cerebral Infarction. The most recent MDS (Minimum Data Set) assessment was an annual assessment with an ARD (assessment reference date) of 8/10/17 has	F 253	RECEIVED NOV 15 2017 VDH/OLC **F253** **Corrective Action(s):** Resident #4 & Resident #5's Low air loss mattresses have been thoroughly cleaned and now have fitted sheets on the low air loss mattress on their beds. The cleaning schedule has been reviewed with the environmental services department. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents utilizing low air-loss mattresses may have potentially been affected. A complete review of all low air-loss specialty mattresses in the facility will be conducted by the administrator, and/or environmental services director to identify Low Air-Loss Specialty Mattresses at risk. All low air-loss mattresses identified at risk will be corrected by the housekeeping department.	11/29/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Adriana C. Chanes	Administrator	11/13/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 253	Continued From page 1 the resident the cognitive status of the resident documented as severely impaired. On 10/18/17 at 8:35 am the clinical record for Resident #4 was reviewed. According to the Physician's Order Sheet, signed and dated 10/ 13 /17 the resident had an order for an air mattress to bed. On 10/18/17 at 3:35 pm Resident #4 was noted to be lying in bed. Air mattress was in place on bed. Resident was noted to be lying on the air mattress with no sheet in between the bed coverings and the resident. On 10/19/17 at 10:15 am surveyor spoke with environmental services personnel about the how often the air mattresses were cleaned. EVS#1(environmental service staff) stated that the" CNAs will ask us to clean the beds when they get the residents out of the bed". "But then you have some residents that don't want to get out of the bed". On 10/19/17 at 10:30 am Resident #4 was noted to be in her room fully dressed and sitting in her wheelchair. Resident #4 bed was noted to be made. An assessment of the air mattress was conducted with resident permission. When the blanket and top sheet were removed from the bed there were large greasy areas noted all over the surface of the air mattress. White spots and flaky white and off white particles were noted on the mattress surface. On 10/19/17 at 11:10 am surveyor spoke with the administrator about the resident lying directly on the air mattress with no sheet in between the bed coverings and the resident and requested	F 253	**Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Environmental Director will provide inservices to all environmental staff on the facility policy and procedure for cleaning specialty mattresses and beds and the notification system to use when cleaning and repairs are needed throughout the facility. **Monitoring:** The Environmental Director and the administrator are responsible for maintaining compliance. Documented rounds will be completed weekly to monitor compliance. The administrator will review the audits weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date:** 11/29/17 RECEIVED NOV 15 2017 VDH/OLC	

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F 253	Continued From page 2	F 253		

information on how often the air mattresses were cleaned. The administrator informed the surveyor that the doctor does not want residents that have orders for air mattresses to have sheets underneath of the resident. There was no definitive answer given as to how often the air mattresses were cleaned.

2. Resident #5 was admitted to the facility on 9/1/16 with a readmission date of 10/13/16. Diagnoses include but not limited to: Muscle Weakness, Chronic Kidney Disease, Viral Hepatitis C, Hemiplegia, and Dementia. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 10/8/17 has the resident's cognitive status as moderately impaired and requiring extensive to total assistance for activities of daily living and transfers.

On 10/19/17 at 8:45 am Resident #5 was noted lying in bed on air mattress with no sheet in between the resident and bed coverings.

On 10/19/17 at 10:10 am Resident #5 was noted to be out of bed and out of the room. The air mattress on Resident # 5 bed was assessed and was noted to have several white spots on the surface of the air mattress covering and a large amount of white, off white, and light brown particles noted on the surface of the air mattress.

On 10/19/17 at 11:10 am surveyor spoke with the administrator about the resident lying directly on the air mattress with no sheet in between the bed coverings and the resident and requested information on how often the air mattresses were cleaned. The administrator informed the surveyor

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F 253	Continued From page 3 that the doctor does not want residents that have orders for air mattresses to have sheets underneath of the resident. There was no definitive answer given as to how often the air mattresses were cleaned. On 10/19/17 at 12:38 pm the administrator, director of nursing, and consultant nurse were made aware of the findings listed in the statements above. No further information regarding this issue was given to the survey team prior to the exit conference.	F 253		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278	**F278** **Corrective Action(s):** Resident #3 has had their most recent MDS modified by the MDS coordinator to accurately code section N-Medications. A facility Incident & Accident form was completed for this incident. Resident #11 has had a modification completed to the most recent MDS to accurately code section K 0200 – Height. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all current resident assessments will be completed by the MDS Coordinator and/or designee to ensure that MDS sections N – Medications and Section K – Height are assessed and coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identified on the most current MDS.	11/29/17

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F 278	Continued From page 4 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure complete and accurate Minimum Data Set (MDS) assessments for 2 of 18 Residents in the sample survey, Resident # 3 and Resident #11. The Findings Included: 1. For Resident #3 the facility staff failed to ensure a complete and accurate Quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 8/6/17. The facility staff inaccurately coded Section N. Medications on Quarterly MDS. The facility staff coded - (a dash) instead of a numerical number between 0 and 7. Resident #3 was an 88 year old female who was admitted on 5/3/17. Admitting diagnoses included, but were not limited to: urinary tract infection, chronic kidney disease, dysphagia, dementia, depression, chronic renal failure, hypertension, congestive heart failure, rheumatoid arthritis and a cerebrovascular	F 278	**Systemic Change(s):** The MDS Coordinator has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all areas of the MDS to include sections K and N of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data. **Monitoring:** The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 11/29/17 RECEIVED NOV 15 2017 VDH/OLC	

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accident.

The most current MDS located in the clinical record was a Quarterly MDS assessment with an ARD of 8/6/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 6. The facility staff also coded that Resident #3 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section N. Medications N0300. Injections the instructions read to "Record the number of days that injections of any type were received during the last 7 days or since admission/entry or reentry if less than 7 days. If 0 -? Skip to N0410, Medications received." The facility staff coded - (dash). In Section N0350. Insulin the instructions read "A. Insulin injections-Record the number of days that insulin injections were received during the last 7 days or since admission/entry or reentry if less than 7 days." The facility staff coded - (a dash). "B. Orders for insulin-Record the number of days the physician (or authorized assistant or practitioner) changed the resident's insulin orders during the last 7 days or since admission/entry or reentry if less than 7 days." The facility staff coded - (a dash). In Section N0410 Medications Received the instructions read "Indicate the number of DAYS the resident received the following medications by pharmacological classification, not how it is used, during that last 7 days or since admission/entry or reentry if less than 7 days. Enter "0" if medication was not received by the resident during the last 7 days." The facility staff coded - for Antianxiety, Antidepressant, Hypnotic, Anticoagulant, Antibiotic and Diuretic.

On October 18, 2017 at 12:45 p.m. the surveyor reviewed Resident #3's clinical record. Review of

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the clinical record produced signed physician orders dated 10/6/17. Signed physician orders did not include physician orders for injections, insulin, antianxiety medications, antidepressants, hypnotics, antibiotics or diuretics during the look back period for the Quarterly MDS assessment with the ARD of 8/6/17. The surveyor noted that Section N. Medications areas should have been coded as "0" for the fields of injections, insulin, antianxiety medications, antidepressants, hypnotics, antibiotics and diuretics.

On October 18, 2017 at 1:35 p.m. the surveyor interviewed the MDS Nurse, who was a Licensed Practical Nurse (LPN #1). The surveyor reviewed the Quarterly MDS with the ARD of 8/6/17 with the MDS Nurse. The surveyor specifically pointed out that Section N was inaccurately coded with - (dashes). The surveyor informed the MDS Nurse that the fields should have been coded with a numerical number between 0-7. The surveyor asked the MDS Nurse who had completed the Quarterly MDS. The MDS Nurse stated that she did not know but would check and see who had completed the MDS.

On October 18, 2017 at 1:45 p.m. the MDS Nurse approached the surveyor and informed the surveyor that she, the MDS Nurse, had completed the Quarterly MDS. The MDS Nurse stated that she had completed the MDS on her second day of employment at the facility. The MDS Nurse stated that she was sorry. The surveyor notified the MDS Nurse that the MDS was inaccurate.

On October 18, 2017 at 2:40 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and Corporate Compliance

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Nurse (CCN). The surveyor informed the Administrative Team (AT) that Resident #3's Quarterly MDS with the ARD of 8/6/17 was inaccurate. The surveyor notified the AT that Section N. Medications on the MDS was coded with a dash. The surveyor notified the AT that the MDS should have been coded with a numerical number of 0-7.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #3.

2. For Resident #11 the facility staff failed to ensure a complete and accurate Admission Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD) of 9/3/17. The facility staff inaccurately coded in Section K. 0200 Height and Weight. The facility staff coded that Resident #11's height was "00."

Resident #11 was a 65 year old male who was admitted on 8/23/17. Admitting diagnoses included, but were not limited to: acute respiratory failure, pneumonia, cerebrovascular accident with hemiplegia, pressure ulcer in sacrum and hip and seizures.

The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an ARD of 9/3/17. The facility staff coded that Resident #11 had short and long term memory impairment (1/1) and was severely impaired with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #11 required extensive (3/2) to total nursing care (4/2) with ADL's. In Section K. 0200 Height and Height the facility

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F 278	Continued From page 8 staff coded that Resident #11's Height was "00." On October 18, 2017 at 3 p.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced documentation that Resident #11's height was 60 inches on admission. On October 18, 2017 at 3:15 p.m. the surveyor interviewed the MDS Nurse, who was a Licensed Practical Nurse (LPN #1). The surveyor reviewed the Admission MDS with the ARD of 9/3/17 with the MDS Nurse. The surveyor specifically pointed out that Resident #11's height was documented as "00." The surveyor reviewed the clinical record with the MDS Nurse and pointed out that Resident #11's height was 60 inches on admission. The MDS Nurse stated she had completed the MDS and was not sure why the height was documented as 0's. The surveyor notified the MDS Nurse that the MDS was inaccurate. On October 19, 2017 at 12:15 p.m. the survey team met with the Administrator (Adm), Director of Nursing (DON) and Corporate Compliance Nurse (CCN). The surveyor informed the Administrative Team (AT) that Resident #11's Admission MDS with the ARD of 9/3/17 was inaccurate. The surveyor notified the AT that Section K Height on the MDS was coded as zero's (00). The surveyor notified the AT that Resident #11's height was documented as 60 inches on admission. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #11.	F 278		

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F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined the facility staff failed to keep the facility environment hazard -free for 1 of 18 residents (Resident #10). Findings: Facility staff failed to ensure Resident #10's environment was hazard free. The record was reviewed on 10/18/17 at 4:00 PM.	F 323	**F323** **Corrective Action(s):** Resident #10's attending physician has been notified that facility staff failed to pad side rails and the wall against bed for safety due to involuntary & purposeless moving and jerking of his limbs. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with a diagnosis of Parkinson's disease or who have involuntary movements may have potentially been affected. The DON, ADON and/or Unit manager will review those residents identified with involuntary movements to identify any residents at risk for possible injury. Any residents identified at risk for injury will have their medical record reviewed by their attending physician for any changes or revisions to the plan of care to prevent or minimize potential injury related to involuntary movements. **Systemic Change(s):** The facility policy and procedure for fall/safety prevention and management has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all nursing staff regarding proper use of fall & safety prevention equipment to include specialty cushions and mattresses to prevent falls and injury. All staff will be inserviced on the correct positioning of all beds, bed rails and safety equipment when they are occupied by residents throughout the day and at night.	11/29/17

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F 323	Continued From page 10 Resident #10 was admitted on 12/14/16. His diagnoses included: anemia, Alzheimer's, Parkinson's and depression. The resident's MDS (minimum data set) assessment, dated 9/24/17, coded the resident with significant cognitive impairment. He required the assistance of a least one nursing staff member to accomplish all the ADLs (activities of daily living). This included bed mobility and transfer assistance. Facility staff failed to ensure Resident #10 had a hospice care plan on file in his clinical record. The record was reviewed on 10/18/17 at 4:00 PM. Resident #10 was admitted on 12/14/16. His diagnoses included: anemia, Alzheimer's disease, Parkinson's disease and depression. The resident's MDS (minimum data set) assessment, dated 9/24/17, coded the resident with significant cognitive impairment. He required the assistance of a least one nursing staff member to accomplish all the ADLs (activities of daily living). The MDS coded one staff member was required for the resident's bed mobility. The resident was unable to reposition himself in bed using a side rail without the help of at least one staff member. Resident #10's CCP (comprehensive care plan) reviewed and revised on 9/25/17, documented the resident had an ADL (activities of daily living) self care deficit. He required the assistance of one staff member for all ADLs. The interventions included: "2 1/2 SR (side rail) to bed for mobility and positioning."	F 323	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will perform daily inspections of all residents with safety interventions and devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews 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:** 11/29/17	

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The CNA care plan, posted inside the resident's closet and dated 9/21/17 documented the resident was to have "side rails...half". The document did not indicated the number of siderails or the positioning of same.

The resident's physician's orders, signed and dated on 9/22/17, did not contain an order for siderails on the bed.

On 10/19/17 at 8:30 AM, the resident was observed in his bed. The bed was flush against the wall on the left side. The right side rail was up in the center of the bed & a fall mat was placed on the floor to the right side of the bed. The resident's eyes were closed and he did not answer when addressed. The resident had multiple jerking episodes with his arms and legs. These motions were involuntary and purposeless.

CNA I entered the room and the surveyor asked about the siderail up in the center of the bed. CNA I stated, "I only been here three weeks. He's trying to get out of bed, that's why I put it up." The CNA said the siderails were always up in the center of the bed when she came to work at 7 AM and that is why she put them back up that way when putting him in the bed. The CNA then pulled up the bottom half of the side rail and left the room.

On 10/19/17 at 8:35 AM RN I was asked where the facility about the resident's siderail placement. She looked into the room and saw two side rails up on Resident #10's bed. She stated, "I hadn't realized that--he shouldn't have two up. The CNA told me he's jumping and jerking a lot more than usual, but he shouldn't have the bottom one up."

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On 10/19/17 at 8:45 AM LPN I was interviewed about the jerking motions and the full side rails up on the bed. She said he had Parkinson's and the jerking motions were sometimes worse, but only the upper rail should be positioned at the head of the bed. "The bottom rail should not be up. Our rails don't flip up so they do cover the middle of the bed. We definitely can't do that to keep them in bed."

On 10/19/17 at 9:30 AM the facility DON (director of nursing) was interviewed. The surveyor told her of the jerking motions and the unpadded side rails on the right side of the bed and the bed being up against the wall. The surveyor expressed concern about the resident involuntarily hitting the unpadded side rail or wall. The DON accompanied the surveyor to Resident #10's room and did a head-to-toe skin assessment to determine whether the resident had struck the wall or side rails and injured himself.

When the DON and surveyor arrived in the room, the right side rail had been padded and there was a cushion between the resident and the wall on the left side of the bed. The DON observed the jerking motions and agreed there was the possibility he could injure himself if the cushions were not in place.

On 10/19/17 at 10:00 AM the DON brought the surveyor a copy of a telephone order provided by Resident #10's physician at 9:10 AM. The order read, "2 1/2 SR (siderails) c (with) padding due to spasms". It was written and signed by LPN I.

On 10/19/17 at 12:45 PM, the facility administrator, DON and corporate nurse were

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F 323	Continued From page 13 informed of the findings. No additional info was provided prior to survey team exit.	F 323		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 514	**F514** **Corrective Action(s):** Resident #4's attending physician has been notified that the facility staff failed to document accurate allergies in the resident's medical record. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all resident's allergies will be conducted by the DON, ADON and/or Resident Care Coordinator to identify residents at risk. All negative findings will be clarified and/or corrected at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This inservice will include obtaining and maintaining accurate allergy records in the medical record.	11/29/17

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F 514	Continued From page 14 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure a complete and accurate clinical record for 1 of 18 residents in the survey sample, Resident #4. The findings include: Resident #4 was originally admitted to the facility on 1/25/11 with 8/2/17 listed as a date of readmission. Diagnoses included but were not limited to Dementia, Hypertension, Major Depressive Disorder, Osteoarthritis, and Cerebral Infarction. The most recent MDS (Minimum Data Set) assessment was an annual assessment with an ARD (assessment reference date) of 8/10/17 has the resident's cognitive status documented as severely impaired. On 10/18/17 at 8:35 am the clinical record for Resident # 4 was reviewed. The clinical record contained a Physician's Order Sheet, signed and dated, 10/13 /17. Resident # 4 had an order for "Aspirin 325 mg tablet give 1 tab po QD". The clinical record indicated that Aspirin was listed as an active allergy according to the October 2017 Physician's Order Sheet. On 10/18/17 at 2:42 pm the administrator, director of nursing, and nurse consultant were made aware of the findings as stated above. On 10/18/17 at 3:29 pm the Infection Control Nurse provided the surveyor with a History and Physical from the clinical record that was dated 7/31/17. Under allergies it was documented "SHE HAS INTOLERANCE TO ASPIRIN WHICH	F 514	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will audit medical records weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 11/29/17	

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F 514	Continued From page 15 MAKES HER NERVOUS". ICF (infection control nurse) stated that the physician was called and made aware that Resident #4 was receiving Aspirin 325 mg as ordered while having an active allergy to Aspirin according to the signed Physician's Order Sheet for October 2017. ICF stated "The doctor gave us an order to d/c (discontinue) the Aspirin allergy". No further information regarding this issue was provided to the survey team prior to the exit conference.	F 514		
F 526 SS=D	483.70(o)(1)-(4) Hospice (o) Hospice services. (1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. (2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply	F 526	**F526** **Corrective Action(s):** Resident #10 & #11's attending physicians have been notified that the facility failed to coordinate a Hospice Care Plan between the facility and Hospice agency for residents #10 & #11. A Facility Incident/Accident form has been completed for each incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents with Hospice Services may have potentially been affected. A 100% audit of residents receiving Hospice Services will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. A Risk Management Incident & Accident form will be completed and proper notification made to the resident's attending physician.	11/29/17

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F 526	Continued From page 16 to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition.	F 526	**Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced by the Administrator and Hospice Director on the policy and procedure for coordinating care and services with the Hospice Agency for all residents receiving Hospice Services. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will review all physician Hospice orders to ensure that the facility has a coordinated Hospice Care Plan for all residents receiving Hospice Services. 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:** 11/29/17	

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F 526	Continued From page 17 (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility.	F 526		

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(J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

(K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

(i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

(ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related

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conditions, and other conditions, to ensure quality of care for the patient and family.

(iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

(iv) Obtaining the following information from the hospice:

(A) The most recent hospice plan of care specific to each patient.

(B) Hospice election form.

(C) Physician certification and recertification of the terminal illness specific to each patient.

(D) Names and contact information for hospice personnel involved in hospice care of each patient.

(E) Instructions on how to access the hospice's 24-hour on-call system.

(F) Hospice medication information specific to each patient.

(G) Hospice physician and attending physician (if any) orders specific to each patient.

(v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff

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furnishing care to LTC residents.

(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.20.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record review and facility document review it was determined that the facility staff failed to coordinate Hospice Services for 2 of 18 Residents in the sample survey, Resident #11 and #10.

The Findings Included:

1. For Resident #11 the facility staff failed to coordinate a Hospice Plan of Care between the facility and Hospice Agency.

Resident #11 was a 65 year old male who was admitted on 8/23/17. Admitting diagnoses included, but were not limited to: acute respiratory failure, pneumonia, cerebrovascular accident with hemiplegia, pressure ulcer in sacrum and hip and seizures.

The most current Minimum Data Set (MDS) located in the clinical record was an Annual MDS assessment with an ARD of 9/3/17. The facility staff coded that Resident #11 had short and long term memory impairment (1/1) and was severely impaired with daily decision making regarding Activities of Daily Living (ADL's). The facility staff also coded that Resident #11 required extensive

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(3/2) to total nursing care (4/2) with ADL's. In Section O. Special Treatments, Procedures, and Programs the facility staff coded that Resident #11 was receiving Hospice Services.

On October 17, 2017 at 6 p.m. the survey team entered the facility and the surveyor requested copies of the facility's contracts with Hospice Services.

On October 18, 2017 at 3 p.m. the surveyor reviewed Resident #11's clinical record. Review of the clinical record produced signed physician orders dated 9/9/17. Signed physician orders included, but were not limited to: "RESIDENT IS ON HOSPICE." (sic)

Continued review of the clinical record produced a Hospice Admission Contract signed by the Hospice Agency and Resident #11's wife on 8/23/17. The admission agreement identified that Resident #11 was to receive "nursing 2 X wk (two times a week) X 2 wks, 1 x wk x 1 wk, 10 PRN (as needed) visits dyspnea, agitation, safety issues, hospice aide 1-2 wk x 13 wks, social work, chaplain, bereavement." (sic)

Further review of the clinical record produced the Hospice Agency notes documenting visits from the Hospice Agency staff.

Additional review of the clinical record failed to produce the Hospice Care Plan to coordinate services between the Hospice Agency and the facility staff.

On October 19, 2017 at 8:20 a.m. the surveyor observed a Licensed Practical Nurse (LPN) sitting at the nurses' station. The surveyor asked the

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LPN if the facility had binders/folders containing Hospice notes and care plans for Residents who were receiving Hospice Services. The LPN stated, "No."

On October 19, 2017 at 9:25 a.m. the surveyor notified the Director of Nursing (DON) that Resident #11 was receiving Hospice Services and that a Hospice Care Plan to coordinate care and services provided by the Hospice Agency could not be located in the clinical record. The surveyor requested a copy of the facility's contract with the Hospice Agency.

On October 19, 2017 at 10 a.m. the surveyor reviewed the facility contract with the Hospice Agency that was providing Hospice Services to Resident #11. The contract was signed on 2/14/06 by the Hospice Agency and on 2/22/06 by the facility's President and Chief Operating Officer. The Hospice Agency contract read in part ...

"2.6 Hospice Plan of Care means a written care plan established, maintained, reviewed and modified, if necessary, at intervals established by the Interdisciplinary Group, which includes: ... 2.7 "Hospice Services means those services provided to a Hospice Patient for the palliation and management of such Hospice Patient's terminal illness, either directly or under arrangement by Hospice, as specified in the Hospice Plan of Care. Hospice Services include nursing care and services by or under the supervision of a registered nurse; medical social services provided by a qualified social worker under the direction of a physician; physician services to the extent that these services are not provided by the Attending Physician; counseling

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F 526	Continued From page 23 services (including bereavement, dietary and spiritual counseling) ; physical therapy, occupational therapy and speech-language pathology services; home health aide; medical supplies; drug and biological; use of medical appliances; and inpatient care when needed for pain control and symptom management. Hospice provides Bereavement Care up to one year, which consists of counseling and support. This service includes a social worker, volunteer and pastoral care." ... 3.2 Design and Maintenance of Hospice Plan of Care a. The Nursing Facilities Residents: In accordance with applicable Federal and state laws and regulations, Hospice shall develop a Hospice Plan of Care for each new Residential Hospice Patient. Promptly upon consent of the Residential Hospice Patient (or his/her legal representative), Hospice shall furnish The Nursing Facility with a copy of the Hospice Plan of Care." On October 19, 2017 at 12:15 p.m. the survey team met with the Administrator (Adm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that the facility staff failed to coordinate Hospice Services with the Hospice Agency. The surveyor notified the AT that a Hospice Plan of Care for Resident #11 could not be located in the clinical record. No additional information was provided as to why the facility and Hospice Agency failed to coordinate Hospice Services that were being provided to Resident #11. For additional information on Resident #11 refer to F Tag 278.	F 526		

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2. Facility staff failed to ensure Resident #10 had a hospice care plan on file in his clinical record. The record was reviewed on 10/18/17 at 4:00 PM.

Resident #10 was admitted on 12/14/16. His diagnoses included: anemia, Alzheimer's, Parkinson's and depression.

The resident's MDS (minimum data set) assessment, dated 9/24/17, coded the resident with significant cognitive impairment. He required the assistance of a least one nursing staff member to accomplish all the ADLs (activities of daily living).

Resident #10's CCP (comprehensive care plan) reviewed and revised on 9/25/17 indicated the resident was documented as receiving hospice services. The CCP recapped the hospice services--but was not specific as to the actual care/services hospice would provide.

Resident #10's clinical record also contained an agreement consent for hopice services, signed by the resident's RP (responsible party). No hospice care plan was observed in the clinical record.

The resident's physician's orders, signed and dated on 9/22/17, contained the following order: "Level of care: Hospice".

On 10/19/17 at 8:45 AM LPN I was asked where the facility stored the hospice care plan documents. The LPN said the hospice service placed them on the chart. She looked but did find them in Resident #10's record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	10/19/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 526	Continued From page 25 On 10/19/17 at 9:30 AM the facility DON (director of nursing) was interviewed. She said the facility could not find the hospice care plan in the clinical record and they were going to have some sent over from the provider. The DON provided the facility agreement for hospice services. It contained the following: ".....Design and maintenance of Hospice Plan of Care. a. The Nursing Facility Residents: In accordance with applicable Federal and state laws and regualtions, Hospice shall develop a Hospice Plan of Care for each new Residential Hospice Patient. Promptly on consent of the Residential Hospice Patient (or his/her legal representative), Hospice shall furnish The Nursing Facility with a copy of the Hospice Plan of Care....." On 10/19/17 at 12:45 PM, the facility administrator, DON and corporate nurse were informed of the findings. No additional info was provided prior to survey team exit.	F 526		