DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	11/02/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 10/31/17 through 11/02/17. 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 120 certified bed facility was 110 at the time of the survey. The survey sample consisted of 19 current Resident reviews (Residents 1 through 19) and 6 closed record reviews (Residents 20 through 25).	F 000		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, facility document review and clinical record review it was determined the facility staff failed to provide access to call lights for 2 of 25 residents (#6 & 7). Findings: 1. Facility staff failed to provide access to a call light for Resident #6. The resident's clinical record was reviewed at 4:15 PM.	F 246	**F246** **Corrective Action(s):** Resident #6's call bell is now properly placed. Unit CNA Staff were inserviced on the proper placement of resident call bell for resident #6. A facility Incident & Accident form was completed for this incident. Resident #7's call bell switch is now properly placed. Unit CNA staff were inserviced on the proper placement of the call bell switch for resident #7. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. The DON and ADON will screen 100% of residents for proper call bell placement and use to identify residents at risk. This is to include adaptive call bells. Any/all negative findings identified will be corrected at the time of discovery. A facility Incident & Accident Forms will be completed for each incident identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: David D. Faulk | TITLE: Administrator | (X6) DATE: 11/17/17

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 246	Continued From page 1 Resident #6 was admitted on 5/3/16. The resident had the following diagnoses: Anemia, GERD, and osteoporosis. The latest MDS (minimum data set) assessment dated 9/25/17, coded the resident as cognitively intact. The resident needed the assistance of one staff member to facilitate hygiene and bathing, but was otherwise independent with staff oversight. Resident #6's CCP (comprehensive care plan) reviewed and revised 9/27/17 acknowledged a self-care deficit. The interventions included, assist with all ADLs (activities of daily living) as needed & provide call light within reach. On 10/31/17 at 3:00 PM, the resident was observed in her bed. Her call light was observed to be hung by the cord on the receptacle where it exited the wall on the other side of a privacy curtain. It was out of reach and out of sight from the resident. Resident #6 told the surveyor it had been up there for several days, since she had returned from her husband's funeral. LPN I removed the call light and placed it on the bed within reach of the resident. On 11/1/17 at 3:00 PM, the administrator and DON were informed of the aforementioned findings. The surveyor requested a copy of the facility policy with regards to call lights. The call light policy included the following: "When the resident is in the bed or confined to a chair be sure the call light is within easy reach of the resident."	F 246	**Systemic Change(s):** Reviewed current facility policy and procedure, no changes warranted at this time. All staff will be inserviced by the DON on the proper placement and use of resident call bells to meet the resident's needs. The unit managers will visually monitor these residents throughout their shift to ensure that the call bells are appropriately place and accessible by each resident at all times. Any negative findings will be corrected at time of discovery and the appropriate disciplinary action taken. **Monitoring:** The DON and/or Unit Managers are responsible for maintaining compliance. DON and/or Unit Managers will complete random daily rounds to monitor for correct placement and compliance. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: 12/01/2017**	

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F 246	Continued From page 2 No additional information was provided prior to the survey team exit. 2. Facility staff failed to provide access to a call light for Resident #7. The resident's clinical record was reviewed on 11/1/17 at 9:00 AM. The resident was admitted to the facility on 11/11/15. The diagnoses included hypertension, coronary artery disease, diabetes, anxiety and psychotic disorder. The latest MDS (minimum data set) assessment dated 8/21/17, documented the resident with severe cognitive impairment. She required the assistance of two staff members to accomplish the ADLs (activities of daily living). Resident #7's CCP, reviewed and revised on 8/25/17, acknowledged the resident had a self-care deficit and was at risk for falls. The CCP did not address the use of call lights. On 10/31/17 at 4:10 PM the resident was observed in her bed. The call light cord was observed to exit the receptacle on the wall and extend to the floor, where the button was found underneath the resident's night stand. The resident had no comment. On 11/1/17 at 3:00 PM, the administrator and DON were informed of the aforementioned findings. The surveyor requested a copy of the facility policy with regards to call lights. The call light policy included the following: "When the resident is in the bed or confined to a chair be sure the call light is within easy reach of the	F 246		

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F 246	Continued From page 3 resident." No additional information was provided prior to the survey team exit.	F 246		
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. 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. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; 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 ensure that physician ordered medications were available for administration for 1 of 25 Resident in the sample survey, Resident #3. The Findings Included: For Resident #3 the facility staff failed to ensure that physician ordered Copaxone and Miracle Mouth Wash were available for administration. Resident #3 was a 39 year old female who was originally admitted on 11/24/14 and readmitted on 5/28/17. Admitting diagnoses included, but were not limited to: multiple sclerosis, hypertension,	F 425	**F425** **Corrective Action(s):** Resident #3's attending physician has been notified that the facility failed to ensure that the physician ordered medications Copaxone, and Magic Mouthwash were available from pharmacy for administration to Resident #3. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. A 100% review of all resident's medication regimes has been conducted by the DON, ADON and/ or Unit managers to identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each. **Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy.	

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F 425	Continued From page 4 major depression, insomnia, anxiety, migraines, restless leg syndrome, mononeuropathy and a fractured radial styloid. The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 9/18/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #3 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On November 1, 2017 at 1 p.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced signed physician orders dated 9/19/19. Signed physician orders included, but were not limited to: "COPAXONE 20MG/ML SYRINGE INJECT 1ML SQ (subcutaneously) Q MWF (every Monday, Wednesday and Friday) DX:MS (diagnoses Multiple Sclerosis)." (sic) This order originated on 5/28/17. Continued review of the clinical record produced a physician's order for "Miracle Mouth Wash GIVE 5MLS SWISH AND SWALLOW Q8HRS (every eight hours) DX; (diagnoses) SORE THROAT." (sic) This order originated on 10/20/17. Further review of the clinical record produced the October 2017 Medication Administration Records (MAR's). Review of the October 2017 MAR's documented that Resident #3's Copaxone was not available for administration on October 4th, 6th and 18th. The October 2017 MAR's documented that pharmacy was notified to send the medication. One of the documentation entries stated that the pharmacy stated the medication	F 425	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON or Unit manager will conduct weekly audits of resident MAR's each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:12/01/2017**	

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F 425	Continued From page 5 would be at the facility later in the evening. The October 2017 MAR's also documented that the Miracle Mouth Wash was not available for administration on October 21, 2017 at 6 a.m., 2 p.m., and 10 p.m., on October 22, 2017 at 2 p.m. and 10 p.m., and October 23, 2017 at 6 a.m. The October 2017 MAR's documented that the Miracle Mouth Wash was not available On November 1, 2017 at 2:15 p.m. the surveyor notified the Director of Nursing (DON) that Resident #3 did not receive her Copaxone and Miracle Mouth Wash as ordered by the physician on multiple occasions in October 2017. The surveyor reviewed the physician orders with the DON. The surveyor specifically pointed out the orders for the Copaxone and Miracle Mouth Wash. The surveyor then reviewed the October 2017 MAR's with the DON. The surveyor specifically pointed out the days that the Copaxone and Miracle Mouth Wash were not available for administration. The surveyor asked who was the facility's primary pharmacy and the DON named a Pharmacy Vendor. The surveyor asked who was the facility's back up pharmacy and the DON named a local pharmacy. The surveyor asked for the facility's policy and procedure for obtaining medications that were unavailable for administration. On November 1, 2017 at 2:35 p.m. the DON hand delivered a Policy and Procedure titled, "7.0 Medication Shortages/Unavailable Medications." The policy and procedure read in part ... "Procedure: 1. Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from	F 425		

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F 425	Continued From page 6 Pharmacy. If the medication shortage is discovered at the time of medication administration, Facility staff should immediately take the action specified in Sections 2 or 3 of this Policy 7.0, as applicable. 2. If a medication shortage is discovered during normal Pharmacy hours: 2.1 Facility nurse should call Pharmacy to determine the status of the order. If the medication has not been ordered, the licensed Facility nurse should place the order or reorder for the next scheduled delivery. 2.2 If the next available delivery causes delay or a missed dose in the resident's medication scheduled, Facility nurse should obtain the medication from the Emergency Medication Supply to administer the dose. 2.3 If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery. 3. If a medication shortage is discovered after normal Pharmacy hours: 3.1 A licensed Facility nurse should obtain the ordered medication from the Emergency Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed Facility nurse should call Pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; or, 3.2.2 Use of emergency (back-up) Third Party Pharmacy." On November 1, 2017 at 3:05 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), DON and Assistant Director of Nursing (ADON). The surveyor notified the Administrative Team (AT) that Resident #3 did not receive her Copaxone and Miracle Mouth Wash on multiple occasions in October 2017.	F 425		

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F 425	Continued From page 7 No additional information was provided prior to exiting the survey as to why the facility staff failed to ensure that physician ordered medications were available for administration for Resident #3.	F 425		