STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 12/4/17 through 12/7/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 130 certified bed facility was 88 at the time of the survey. The survey sample consisted of a total of 22 residents. This included 19 current resident reviews and 3 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(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, staff interview, Resident interview, clinical record review, and facility documentation review, the facility staff failed to accommodate the needs of 2 Residents, (Resident #487, and #26) of the 22 Residents in the survey sample. 1. For Resident #487, the facility staff failed to have a call system in place. 2. For Resident #26, the facility staff failed to accommodate her preference to attend worship activity within the facility.	F 558	RECEIVED DEC 21 2017 VDH/OLC 1-15-18 **F558** **Corrective Action(s):** Resident #487's call bell was corrected and is now properly placed. Unit CNA Staff were inserviced on the proper placement of resident call bell for resident #487. A facility Incident & Accident form was completed for this incident. Resident #26 was reassessed by the nursing department to establish her AM routine for ADL care and dressing to establish the resident requested time to be up and out of bed in the morning. Her comprehensive care plan has been updated to reflect her wishes to be up and dressed by 9:30am on the weekends so she can attended worship services. A facility Incident & Accident form was completed for this incident.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Pamela LeCann	Administrator	12-20-17

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 558	Continued From page 1	F 558		

The findings included:

1. Resident #487 was recently admitted to the facility, on 11-20-17, with diagnoses that included; Hypertension, heart failure, urine retention, pneumonia, dementia, anxiety, dysphagia, and major recurrent depression.

On 12-4-17 at 12:30 p.m., an initial tour was conducted of the facility, and the Resident was observed, and interviewed. The Resident was sitting in a wheel chair, on the side of her bed at the foot end. The Resident was wrapped in a blanket that she was sitting on, in the chair, and the blanket extended from her neck to her knees. The Resident was complaining of being "cold". The Resident was asked if she could use her call bell to summon staff assistance, and she stated "I don't know where it is." The call bell cord was noted to be plugged into the wall behind the head of the bed, and dangling down behind the head of the bed, resting on the floor. A staff member came to the door and stated "Ms. (name), we will be carrying you to lunch in just a minute." The staff member was asked if the Resident could self-propel in the wheel chair, and she stated "no, she is too weak, we have to push her." The Resident was wearing a nasal cannula with oxygen infusing at 4 liters per minute. The Resident was physically unable to come out of the room to ask for help.

During Resident record review, Resident #487's full admission MDS (minimum data set) was found to be not yet submitted to CMS (Centers for Medicare and Medicaid Services). The Resident had only been a resident in the facility for 13 days at the time of survey.

Identification of Deficient Practices & Corrective Action(s):
All other residents may have potentially been affected. The DON, ADON and/or unit managers 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.
The activity director and/or Social services director will interview all residents on their preference to attend worship services on the weekends and establish a list of residents requiring assistance to be up and dressed to attend worship services on the weekends.

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 Social Services Director or Activity director will inservice all nursing staff on the established resident listing for worship services on the weekends and the expectation that residents are to be up and ready to attend each service at the proper start times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 558	Continued From page 2	F 558		

During the clinical record review, an admission nursing care plan was found, and it was reviewed. The care plan revealed that Resident #487 was documented as requiring assistance for all activities of daily living. The Resident was documented as requiring oxygen at 2 liters per minute via nasal cannula.

Facility Policy & Procedure on the call bell system documented, "All call lights will be answered promptly." Resident #487 was not able to summon help.

On 12-6-17, and 12-7-17, the Administrator and Director of nursing were made aware of the lack of call bell accommodation for Resident #487. No further information was provided by the facility.

2. For Resident #26, the facility staff failed to accommodate her preference to attend worship activity within the facility.

Resident #26 was 85 years old when admitted to the facility on 5/1/13. Resident #26's diagnoses included Hypertension, Diabetes Mellitus, Neurogenic Bladder, Anxiety, and Depression.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 10/4/17, coded Resident #26 as having a Brief Interview of Mental Status Score of 15, indicating no cognitive impairment. Resident #26 was also coded as requiring the extensive physical assistance of two persons for bathing, dressing, transfers, and mobility.

On 12/04/17 at 12:01 P.M., an interview was

Monitoring:
The DON and/or Unit Managers are responsible for maintaining compliance. DON and/or Unit Managers will complete random daily rounds throughout the day to monitor for correct placement of call bells to monitor for compliance. The charge nurses are responsible for ensuring all residents on the established worship service list will be up and dressed and in attendance for worship services on the weekends. An attendance form will be completed for each worship sheet to monitor for compliance. Any negative findings will result in disciplinary action as required. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.
Completion Date: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 558	Continued From page 3	F 558		

conducted with Resident #26. She stated that she has asked repeatedly to be assisted to attend church on Saturday and Sunday at 10 A.M., and that facility staff consistently bring her in late when the worship service is almost over.

On 12/6/17 a Group Interview was conducted with approximately 20 residents. The majority of residents agreed that they often miss church service on the weekends because staff don't get them dressed and ready to attend timely. This happens on Saturday and Sunday because staff take residents outside of the facility to smoke earlier and that the official time, was 10:30 A.M. Resident #26 stated that she was upset because this also happened when her brother came from out of town to visit with her and attend the worship service. She often does not arrive until 10:45 when the worship activity is about to conclude.

On 12/6/17 at 1:30 P.M. an interview was conducted with the Activities Coordinator (Employee G). She confirmed that Resident #26 regularly attended the worship activity on the weekends. She also confirmed that residents arrive late for the activity.

On 12/6/17 at 4:30 P.M. the facility Administrator (Administration A), and Director of Nursing (DON-Administration B) were informed of the findings. The DON stated that the facility staff would get the residents dressed earlier. No further information was received.

F 641 SS=D Accuracy of Assessments
CFR(s): 483.20(g)

F 641

§483.20(g) Accuracy of Assessments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 641	Continued From page 4	F 641		1-15-18

The assessment must accurately reflect the resident's status.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure an accurate and complete MDS (minimum data set) for one Resident (Resident #58) of 22 Residents in the survey sample.

For Resident #58, the facility staff inaccurately coded the special treatments status at Section "O" for the MDS assessment with "Transfusions were received while a Resident".

The findings included:

1. Resident #58 was admitted to the facility on 5-31-17 with the diagnoses of, but not limited to, pressure ulcer, kidney disorder, dysphagia, irritable bowel syndrome, contractures both ankles, anxiety, depression, manic depression, anemia, neurogenic bladder; diabetes, wound infection, and quadriplegia.

Resident #58's most recent MDS (minimum data set) with an ARD (assessment reference date) of 11-2-17 was coded as a quarterly assessment. Resident #58 was coded as having a BIMS (brief interview of mental status) score of 15 out of a possible 15 points, revealing no cognitive impairment. Resident #58 was also coded as requiring total dependence on one to two staff members for all activities of daily living, such as bed mobility and hygiene. In Section O-"Special procedures", Resident #58 was coded as having blood transfusions while in the long term care facility.

F641
Corrective Action(s):
Resident #58 has had their most recent MDS modified and corrected by the MDS coordinator to accurately code section O for no blood transfusions while in facility. 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 O – Special Treatments, Procedures & Programs is 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.

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 O 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 641	Continued From page 5 Review of the clinical record revealed no history of the Resident receiving a blood transfusion while in the facility. No physician's order existed in the clinical record for this procedure, and no documentation existed for this procedure in the nursing care plan. On 12-6-17 at approximately 10:00 a.m. an interview was conducted with Registered Nurse (RN) A, and Employee A, the MDS coordinators. The 2 staff members stated, "It was coded incorrectly." "No transfusions have been done in this facility, we don't do that." On 12-6-17, and 12-7-17, at the end of day debriefs, the Administrator and Director of Nursing were made aware of findings. No further information was provided by the facility.	F 641	**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: January 15, 2018**	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders.	F 655	**F655** **Corrective Action(s):** Resident #58's attending physician and RP were notified that the facility failed to develop a base line care plan for resident #58 with 48 hours of admission. A Facility Incident & Accident Form was completed for this incident.	1-15-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 655	Continued From page 6	F 655		

(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility failed for one Resident, Resident 86, in a survey sample of 22 residents, to ensure a baseline care plan was initiated within 48 hours.

Resident #86's initial care plan was initiated 8 days after his admission.

The findings included:

Resident #86 was admitted to the facility on

Identification of Deficient Practices & Corrective Action(s):
All residents may have potentially been affected. A 100% review of all new admissions in the last 30 days will be conducted by the DON, RCC and/or designee to identify residents without a base line care plan within 48 hours of admission. All resident identified with base line care plans developed after 48 hours of admission will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs and the attending physician and RP will be notifed. A Facility Incident & Accident Form will be completed for each incident identified.

Systemic Changes:
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise base line care plans within 48 hours of admission to the facility. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development and implementation process of base line care plan within 48 hours of admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 655 Continued From page 7

11/20/17. Diagnoses included, but not limited to, stroke with hemiparesis, alcohol abuse.

The resident has had no MDS (minimum data set) completed as he was a new admission. Care notes documented the resident required extensive to maximum assistance of two staff members.

Resident # 86's initial care plan completed 8 days after admission. DON stated, "Should be done 24 hours after admission. The only date on the document was the completion date.

On 12/07/17 at 9:05 AM an interview was conducted with RN (registered nurse) A, the MDS coordinator, regarding interim care plans. She stated, "The interim care plan form is included in the admission packet. The admit date is the initiation date."

On 12/7/17 at approximately 11:15 AM, the Administrator and DON (director of nursing) were notified of above findings.

F 655

Monitoring:
The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits on all new admissions 48 hours after admission to ensure a base line care plan has been completed timely. Any/all negative findings will be reported to the RCC for immediate correction. Detailed findings of the Care Plan 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: January 15, 2018

F 657 Care Plan Timing and Revision
SS=D CFR(s): 483.21(b)(2)(i)-(iii)

§483.21(b) Comprehensive Care Plans
§483.21(b)(2) A comprehensive care plan must be-
(i) Developed within 7 days after completion of the comprehensive assessment.
(ii) Prepared by an interdisciplinary team, that includes but is not limited to--
(A) The attending physician.
(B) A registered nurse with responsibility for the resident.
(C) A nurse aide with responsibility for the

F 657

1-15-18

F657
Corrective Action(s):
Resident #52's comprehensive care plan and C.N.A. closet Care plan have been reviewed and revised to reflect the interventions in place for wound care treatment and prevention for pressure injuries on the foot and ankle are. A Facility Incident & Accident Form was completed for this incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 657	Continued From page 8 resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #52) of 22 residents in the survey sample to review and revise the care plan. For Resident #52, the care plan did not include interventions to prevent the development of the pressure ulcer to the right heel. The findings included: Resident #52, an 81 year old, was admitted to the facility on 5/11/11. Diagnoses included stroke, aphasia, dementia, atrial fibrillation, hypertension. The most recent minimum data set assessment was a quarterly assessment with an assessment reference date of 10/20/17. Resident #52 was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. He required assistance with his activities of daily	F 657	**Identification of Deficient Practices & Corrective Action(s):** Any/all residents who have a wound may have potentially been affected. A 100% review of their comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk for inaccurate wound care and preventions care planned. Residents identified at risk will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant and/or RCC will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in resident condition.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 657	Continued From page 9	F 657		

living (ADL) and was coded to have 1 stage 3 wound.

Resident #52 had a right heel wound measuring 3.0 x 2.5 x. 0.1 centimeters when first assessed by the wound care doctor on 9/20/17.

Resident #52's care plan was dated 8/31/17. The problem read "potential for impaired skin integrity due to right sided hemiparesis. HX (history) of pressure ulcers. HX (history) of being non compliant with interventions and treatment plans. Refuses showers at times Open wound to right lateral ankle- resolved. HX (history) of cellulitis." Handwritten under this section read "ref. (refuse) to elevate lower ext (extremities) @ times". The "Approaches" section read assist with turning, pressure reducing cushion to wheel chair, lift sheet for positioning, bowel and bladder program every 2 hours, wound consult as needed. There is no documentation of interventions specific to the feet and ankles.

The "CNA Care Plan" was hung on the resident's closet door. The care plan read "Information is current as of this date: 9/26/17." The interventions "elevate heels off surface, turn & reposition, and pressure relieving boots" were pre-printed on the care plan. None of these interventions were circled or identified to be care interventions for Resident #52.

During the interview with the NP, DON and Assistant DON (ADON) on 12/7/17 at 9:15 a.m., the ADON stated that Resident #52 was known to refuse care. It was reviewed with the ADON that there were no interventions specific to prevention of foot and ankle wounds documented on the care plan. The ADON stated that she needed to

Monitoring:
The RCC and DON will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's 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: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 657	Continued From page 10	F 657		

take a look at the clinical record.

The ADON provided a copy of an old care plan dated 2/2/17 that included the intervention "7/13/17 Float heels as resident will tolerate."

Resident #52's care plans were discussed with LPN C. LPN C stated that the care plan dated 2/2/17 was old and had been thinned. She stated the care plan dated 8/31/17 was the current care plan. When asked if the intervention, "Float heels as resident will tolerate", should have been included on the 8/31/17 care plan, she stated "yes". When asked if a doctor's order was needed for pressure relieving boots, LPN C stated yes.

LPN C stated that she also updated the CNA Care Plan and was responsible for keeping it up to date. The CNA care plan did not indicate that Resident #52's heels were supposed to be floated. LPN C stated that the CNA Care plan that was in place prior to 9/26/17 would have been discarded.

The care plan issue was reviewed with the Administrator, DON and corporate staff at the end of day meeting on 12/7/17.

F 686 SS=D Treatment/Svcs to Prevent/Heal Pressure Ulcer
CFR(s): 483.25(b)(1)(i)(ii)

§483.25(b) Skin Integrity
§483.25(b)(1) Pressure ulcers.
Based on the comprehensive assessment of a resident, the facility must ensure that-
(i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure

F 686

F686
Corrective Action(s):
Resident #52's attending physician was notified that there were no preventative measure in place for the prevention and treatment of ankle and foot wounds. Resident #52 has been re-assessed by nursing and the attending physician/NP for compromised skin integrity and that preventative measure are in place for the prevention of ankle & foot wounds. The comprehensive care plan and the closet care plan have been updated to reflect the current preventative skin care approaches and interventions to prevent skin breakdown.

1-15-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 686	Continued From page 11	F 686		

ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review the facility staff failed for 1 resident (Resident #52) of 22 residents in the survey sample to prevent and assess a pressure ulcer to the right heel.

For Resident #52, no interventions were in place to prevent the development of the pressure ulcer. Once the ulcer was identified, it was not correctly assessed by facility staff.

The findings included:

Resident #52, an 81 year old, was admitted to the facility on 5/11/11. Diagnoses included stroke, aphasia, dementia, atrial fibrillation, hypertension.

The most recent minimum data set assessment was a quarterly assessment with an assessment reference date of 10/20/17. Resident #52 was coded with a Brief Interview of Mental Status score of 3 indicating severe cognitive impairment. He required assistance with his activities of daily living (ADL) and was coded to have 1 stage 3 wound.

Resident #52 was first observed on 12/04/17 at 2:30 PM. Resident #52 was lying in bed with his feet flat on the mattress. A purple pressure relieving boot was observed on the floor behind

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents with pressure injuries may have been potentially affected. A 100% review of all residents care plans with pressure injuries will be completed to identify any skin or pressure related issues that do not have preventative measure in place and care planned to reduce/prevent pressure injuries. Any negative findings will be addressed at the time of discovery, the attending physician notified and a facility incident and accident form will be completed.

Systemic Change(s):
The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON and/or regional nurse consultant(s) on the facility's Pressure Ulcer Treatment and Prevention Policy and Procedure. Training will include, performing weekly body audits, assessing risk for pressure ulcers using Braden scale, preventative measures, and implementation of treatment orders per facility protocol. All preventative measures will be included on their care plan and the C.N.A closet care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 686	Continued From page 12	F 686		

the head of the bed. When asked if he ever wears the boot, the resident stated "yes".

On 12/5/17, morning, the purple pressure relieving boot was observed in the same spot on the floor behind the head of the bed.

On 12/7/17 at 12:40 p.m., Resident #52's right heel was observed in the presence of another surveyor and Certified Nursing Assistant B (CNA B). CNA B removed Resident #52's shoe and sock. Resident #52's right heel wound was closed and healed.

According to the nursing notes, the right heel wound was first observed on 9/16/17. The nursing note read, "open area noted to right heel during ADL care by CNA. Small amount of bloody drainage. Assessed by this nurse and NP notified and treatment applied. RP called and message left to call facility."

A treatment was started on 9/16/17. The order read "medi honey to R heel post cleansing w DWC (Dakins wound cleanser) and apply coveusite drsg (dressing)." The order was implemented according to the September 2017 Treatment Administration Record (TAR).

On 9/18/17, a wound consult was ordered.

On 9/20/17, the wound doctor assessed the wound. The evaluation note read "He presents with a stage 3 pressure wound of the right heel of at least 1 days duration." The wound was measured 3.0 x 2.5 x. 0.1 centimeters. It was described as 100% granulation tissue with moderate sero-sanguineous drainage. Recommendations included float heels while in

Monitoring:
The DON and/or MDS coordinator is responsible for maintaining compliance. The DON and/or MDS coordinator will complete weekly audits of all resident care plans with Pressure Ulcer preventative orders to ensure they are being properly care planned and implemented per physician order. Any negative findings will be corrected at the time of discovery and disciplinary action will be taken as needed. All weekly audits will be reviewed weekly by the Risk Management Committee for appropriate implementation of prevention orders. The weekly risk management minutes will be reviewed by the DON and provide results of these audits to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 686	Continued From page 13	F 686		

bed. off-load wound, reposition per facility protocol.
A new dressing was ordered "dry protective dressing- once daily, silver alginate- once daily "

Licensed Practical Nurse F (LPN F), quality assurance nurse, completed the "Wound Assessment Report on 9/20/17. It included the exact same information from the wound doctor's assessment.

During an interview with the Director of Nursing (DON) on 12/7/17 at 9:15 a.m., the DON stated that it was the facility process for LPN F to directly copy the information from the wound doctor note into the facility's wound assessment reports.

The DON was asked to explain the process for assessing and documenting pressure ulcers. She stated that when the nurse was notified that a wound was present, the nurse was supposed to document the wound description, measurements, treatment order and notifications of doctor and responsible party.

It was reviewed with the DON that the nurse that completed the nursing note on 9/16/17 did not measure the wound or describe the wound bed. The DON agreed that this information was not documented as it should have been.

It was reviewed with the DON that the wound care doctor documented Resident #52's wound as a stage 3 on first assessment (4 days after the wound was found by facility staff). At this time, the Nurse Practitioner (NP) stated that she had reviewed the wound care doctor's assessments of the wound (on this day, 12/7/17) and was in disagreement with the documentation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 686	Continued From page 14	F 686		

staging. The NP was asked if she ever saw the wound. She stated no. The NP stated that she felt the wound doctor incorrectly staged the wound. The NP stated that she felt that a wound with the depth of 0.1 centimeters was a partial thickness wound (stage 1-2) rather than a full thickness wound (stage 3-4). She stated that the wound doctor's staging of the wound as a stage 3 was incorrect. The NP also questioned the description of the wound being 100% granulation tissue.

When asked if they had identified issues with other residents regarding the wound care doctor's staging of wounds, the DON stated that Resident #52's wound was the first that they had reviewed.

The DON stated that the wound care doctor assessed all pressure wounds. The DON stated that a nurse was present with the wound doctor during his rounds, but the nurse did not assess the wound. The nurse was there to document changes in treatment orders.

For Resident #52, the nurse who first documented the wound on 9/16/17 did not measure the wound or describe the wound bed in her note. The NP and DON stated during their interview that the wound care doctor did not accurately describe or stage Resident #52's wound. The DON stated that the quality assurance nurse used the wound care doctor's assessment to complete the facility wound assessment report. As a result, there was no accurate assessment of Resident #52's pressure ulcer in his clinical record.

Resident #52's care plan was dated 8/31/17. The problem read "potential for impaired skin integrity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 686	Continued From page 15	F 686		

due to right sided hemiparesis. HX (history) of pressure ulcers. HX (history) of being non compliant with interventions and treatment plans. Refuses showers at times Open wound to right lateral ankle- resolved. HX (history) of cellulitis." Handwritten under this section read "ref. (refuse) to elevate lower ext (extremities) @ times". The "Approaches" section read assist with turning, pressure reducing cushion to wheel chair, lift sheet for positioning, bowel and bladder program every 2 hours, wound consult as needed. There is no documentation of interventions specific to skin care of the feet and ankles.

The "CNA Care Plan" was hung on the resident's closet door. The care plan read "Information is current as of this date: 9/26/17." The interventions "elevate heels off surface, turn & reposition, and pressure relieving boots" were pre-printed on the care plan. None of these interventions were circled or identified to be care interventions for Resident #52.

During the interview with the NP, DON and Assistant DON (ADON) on 12/7/17, the ADON stated that Resident #52 was know to refuse care. It was reviewed with the ADON that there were no interventions specific to prevention of foot and ankle wounds documented on the care plan. The ADON stated that she needed to take a look at the clinical record.

The ADON provided a copy of an old care plan dated 2/2/17 that included the intervention "7/13/17 Float heels as resident will tolerate."

Resident #52's care plans were discussed with LPN C. LPN C stated that the care plan dated 2/2/17 was old and had been thinned. She stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 686	Continued From page 16	F 686		

the care plan dated 8/31/17 was the current care plan. When asked if the intervention, "Float heels as resident will tolerate", should have been included on the 8/31/17 care plan, she stated "yes". When asked if a doctor's order was needed for pressure relieving boots, LPN C stated "yes".

LPN C stated that she also updated the CNA Care Plan and was responsible for keeping it up to date. The CNA care plan did not indicate that Resident #52's heels were supposed to be floated. LPN C stated that the CNA Care plan that was in place prior to 9/26/17 would have been discarded.

The issue was reviewed with the Administrator, DON, and corporate staff at the end of day meeting on 12/7/17.

F 688 SS=D — Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3)

§483.25(c) Mobility.
§483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

§483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

§483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with

F 688

1-15-18

F688
Corrective Action(s):
Resident #38 has been reassessed by the attending physician/NP and the therapy department for the proper wheelchair and wheelchair aids to safely transport resident #38. A risk management Incident & Accident form was completed for this incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 688	Continued From page 17	F 688		

the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview, and clinical record review, the facility staff failed, for 1 resident (Resident #38) in the survey sample of 22 residents, to provide a safe form of transport within the facility.

The facility staff failed to provide Resident #38 a safe form of transport, after her ankle was fractured in 2 places while being transported by staff in a standard wheelchair without leg rests/food petals.

The Findings included:

Resident #38 was 69 years old when admitted to the facility on 4/29/16. Resident #38's diagnoses included Altered Mental Status, Encephalopathy, Heart Failure, Hypertension, and Diabetes Mellitus.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 10/12/17, coded Resident #38 as being able to understand and be understood by others. She was also coded as having fluctuating inattention and disorganized thinking. She was coded as requiring the extensive physical assistance of one staff person for locomotion, dressing and personal hygiene.

On 12/5/17 an interview was conducted with Resident #38. She stated, "Aides took me to the beauty parlor to get my hair washed. They said we had to move fast because the the beauty parlor was closing. One aide pushed me fast

Identification of Deficient Practices/Corrective Action(s):
All other residents requiring assistive devices for transport may have been potentially affected. The facility will conduct a 100% audit of all residents using wheelchairs for mobility to ensure they are able to be transported safely with the current interventions and wheelchair in place to identify residents at risk. Any/all residents identified at risk with be reassessed by the therapy department to establish a safe transport mode for the resident. A Risk Management Incident & Accident Form will be completed for each incident.

Systemic Change(s):
The facility policy & procedure has been reviewed and no revisions are warranted at this time. All nursing staff will be inserviced by the Director of Nursing and/or Therapy Director on the policy and procedure for providing safe transportation to and from activities and the use of physician ordered assistive devices and services to improve or maintain safe resident mobility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 688 Continued From page 18

while the other one walked with us and said to hurry up. I didn't have foot rests. My foot went down and my left ankle broke in 2 places. It happened in the hallway. I screamed, and was sent to the hospital."

On 12/5/17 a review was conducted of Resident #38's clinical record, revealing that on 4/27/16, she sustained a fractured ankle while being transported by staff in a wheelchair without leg rests/ foot petals.

On 12/7/17 at 1:30 P.M. an interview was conducted with Resident #38. Resident #38's wheelchair was next to her bed. It didn't have leg rests/ foot petals. There were no leg rests/ foot petals in her closet. According to the clinical record, and the statement by Resident #38, prior to the ankle fracture, she used her feet to ambulate around the facility in her wheelchair. After the fracture, Resident #38 had spent the majority of her time in bed. She stated that staff take her out of her room for showers, and that she doesn't feel safe in the wheelchair without leg rests/foot petals. When asked if the staff had installed leg rests/foot pedals on her wheelchair after the fracture, she stated, "They threw something together that was unsteady. They didn't hold my feet properly. They tried to crunch up my foot. The pedal was wobbly. My feet would just slip right off the pedals. When they put me in the wheelchair, I could feel myself leaning forward at the gap between my lower back and the back of the wheelchair. I would always slide forward I was sometimes afraid of falling out."

On 12/7/17 a review of Resident #38's clinical record was conducted. The Care Plan read, "7/3/17. Requires extensive assist/total

F 688

Monitoring:
The DON and Therapy manager are responsible for maintaining compliance. The DON, Therapy manager and/or Unit managers will perform daily audits to ensure that all assistive devices are in place to proved safe resident transport. All negative findings will be corrected at time of discovery and reported to the Risk Management Committee weekly for review and recommendations. Disciplinary action will be taken as needed. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.
Completion Date: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 688	Continued From page 19 assistance with ADL (Activities of Daily Living) care. Prefers to stay in bed majority of the time. Will attend at least 2 out of room activities of interest through next review." On 12/7/17 at 1:30 P.M. an interview was conducted with the Director of Rehabilitation (Employee F). When asked why Resident #38 did not have a safe form of transport, the Director of Rehabilitation stated that Resident #38 had refused to get out of bed. When asked if Resident #38's wheelchair had been altered, or adapted or adjusted in any manner since the ankle fracture occurred, she stated, "No." The Director of Nursing was also present (DON -Administration B). They both agreed that Resident #38 is taken via her wheelchair twice weekly for showers, and to have her hair washed. They both were unable to state a specific plan to ensure a safe form of transport to engage in activities of daily living. On 12/7/17, the Administrator was informed of the findings. No further information was received.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that-	F 690	**F690** **Corrective Action(s):** Resident #29's Foley bag is now anchored per policy and procedure to ensure it is off the floor to prevent infection and injury. The resident's care plan has been revised to reflect accurate Foley catheter care to include proper placement of the drainage bag.	1-15-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 690 Continued From page 20

(i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary;
(ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and
(iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation review and clinical record review, the facility staff failed to ensure that a urinary catheter drainage bag was maintained in a manner to prevent the spread of infection for one resident (Resident # 29) in a survey sample of 22 residents.

For Resident # 29, the facility staff failed to ensure the urinary catheter bag was not resting the floor. Resident # 29 was observed to be sitting in a wheelchair in the dining room with his urinary drainage bag touching the floor.

The findings included:

F 690

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents with a Foley catheter may have been potentially affected. The DON, ADON and or Unit Manager will conduct a 100% review of all residents with a Foley catheter to identify residents at risk. Residents identified will be corrected at time of discovery and a Facility Incident & Accident Form will be completed.

Systemic Change(s):
The facility Policy and Procedure for Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON on the policy and procedures for proper Foley Catheter care to include the proper anchoring of Foley catheter tubing and proper placement of the drainage bag to prevent infection and injury.

Monitoring:
The Director of Nursing is responsible for maintaining compliance. The DON and/or Unit Manager will make daily random audits of all Foley Catheter's to ensure compliance with anchoring of tubing and proper placement of drainage bags to monitor compliance. All negative findings will be corrected at time of discovery. Detailed 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: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 690	Continued From page 21	F 690		

Resident # 29 was a 67-year-old male who was admitted to the facility on 8/23/2007, readmitted on 7/11/2016 and 9/29/2017 with diagnoses of but not limited to: Hypertension, Diabetes, Acute Kidney Failure, Gastroesophageal Reflux Disease, Venous Insufficiency, Fluid Overload, Pulmonary Hypertension, Peripheral Vascular Disease, Neurogenic Bladder and Edema.

The most recent Minimum Data Set (MDS) was a Significant Change Assessment with an Assessment Reference Date (ARD) of 10/6/2017. The MDS coded Resident # 29 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of 1 staff person with Activities of Daily Living except required supervision and set up for eating; and coded as always incontinent of bowel and an indwelling catheter for bladder.

12/04/17 2:25 PM Observed Resident sitting in Dining Room in wheelchair. Indwelling catheter bag resting on the floor.

12/05/17 10:00 AM Observed Resident sitting in Dining Room in wheelchair. Indwelling catheter bag resting on floor

12/05/17 12:45 PM Observed Resident sitting in Dining Room in wheelchair. Indwelling catheter resting on floor.

12/05/17 2:00 PM-3:05 PM Resident sitting in Dining Room in wheelchair during Group Interview. Catheter bag resting on floor throughout meeting.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 690	Continued From page 22	F 690		

12/5/17 3:10 PM, the Director of Nursing was in the Dining Room checking on another resident. When the surveyor asked about Resident # 29's catheter bag, the DON stated the catheter bag was on the floor and should not rest on the floor. The DON stated the catheter bag kept dropping lower and that she had to lift it higher twice the night before because it had begun to touch the floor. The DON stated she thought the catheter bag would shift periodically. The Corporate Consultant (Admin D) came into the Dining Room and stated the drainage bag should not rest on the floor. Admin D stated she was going to take Resident # 29 to his room to correct the issue. Admin D began to turn Resident # 29's wheelchair. The DON stopped Admin D and instructed her to raise the catheter bag prior to transporting the resident.

Review of the clinical record revealed Resident # 29 had a Suprapubic Catheter. Review of the Physicians Orders revealed orders to Monitor Suprapubic Foley output every shift and Cleanse Suprapubic area with wound cleanser, pat dry, apply sponge to area twice a day.

On 12/6/2017 at 4:00 PM, observed nurse, (Licensed Practical Nurse E) providing treatment to the Suprapubic site as ordered by the physician. Suprapubic site appeared clean and dry. No issues were noted with the administration of the treatment.

Review of the Facility Document entitled Catheter Care, Urinary revised 9/2017, Under Infection Control stated:

"2. b. Be sure the catheter tubing and drainage bag are kept off the floor."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 690	Continued From page 23	F 690		

During the end of day debriefing on 12/6/2017 at approximately 4:45 PM, the Director of Nursing, Administrator and Corporate Consultants were informed of the findings.

No further information was provided.

F 695 SS=D Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, resident interview, and clinical record review, the facility staff failed to ensure a correct oxygen infusion rate for 2 Residents (Resident #487, and #41) of 22 residents in the survey sample.

1. Resident #487 failed to have 2 liters of oxygen infusing, and instead, had 4 liters of oxygen infusing.

2. For Resident # 41, the facility staff failed to ensure the oxygen tank was not empty on 12/5/2017.

The findings included:

1. Resident #487 failed to have 2 liters of oxygen

F 695

F 695
Corrective Action(s):
Resident #487 has had their oxygen administration orders clarified with the attending physician. The attending physician has been notified that Resident #487 did not receive oxygen at the correct flow rate as ordered by the physician. A facility Incident & Accident form has been completed for this incident.

1-15-18

Resident #4's attending physician was notified that resident #41 did not receive oxygen at the correct flow rate as ordered by the physician for approximately 55 minutes during the resident interview meeting. A facility Incident & Accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON and/or ADON to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 695	Continued From page 24	F 695		

infusing, and instead had 4 liters of oxygen infusing.

Resident #487 was recently admitted to the facility, on 11-20-17, with diagnoses that included; Hypertension, heart failure, urine retention, pneumonia, dementia, anxiety, dysphagia, and major recurrent depression.

On 12-4-17 at 12:00 p.m., an initial tour was conducted of the facility, and the Resident was observed, and interviewed. The Resident was sitting in a wheel chair, on the side of her bed at the foot end. The Resident was wrapped in a blanket that she was sitting on, in the chair, and the blanket extended from her neck to her knees. The Resident was complaining of being "cold". The Resident was asked if she could use her call bell to summon staff assistance, and she stated "I don't know where it is." The call bell cord was noted to be plugged into the wall behind the head of the bed, and dangling down behind the head of the bed, resting on the floor. A staff member came to the door and stated "Ms. (name), we will be carrying you to lunch in just a minute." The staff member was asked if the Resident could self-propel in the wheel chair, and she stated "no, she is too weak, we have to push her." The Resident was wearing a nasal cannula with oxygen infusing at 4 liters per minute. The Resident was physically unable to come out of the room to ask for help.

On 12-4-17 two further observations were conducted of the Resident at 2:51 p.m., and 3:25 p.m., during all three observations from 12:00 p.m. to 3:30 p.m., the Resident was receiving 4 liters of oxygen infusing via nasal cannula continuously.

Systemic Change(s):
The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order and the monitoring of portable oxygen tanks throughout the shift.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or ADON will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 695	Continued From page 25	F 695		

During Resident record review, on 12-4-17, and 12-5-17, Resident #487's full admission MDS (minimum data set) was found to be not yet submitted to CMS (Centers for Medicare and Medicaid Services). The Resident had only been a resident in the facility for 13 days at the time of survey.

During the clinical record review, an admission nursing care plan was found, and it was reviewed. The care plan revealed that Resident #487 was documented as requiring assistance for all activities of daily living. The Resident was documented as requiring oxygen at 2 liters per minute via nasal cannula continuously.

During the clinical record review physician's orders were reviewed and revealed a current order for oxygen 2 liters per minute via nasal cannula continuously.

During the clinical record review, the Medication Administration record (MAR) was reviewed. The MAR revealed signatures that the Resident was receiving 2 liters of oxygen per minute via nasal cannula continuously.

On 12-6-17, and 12-7-17, the Administrator and Director of nursing were made aware of the oxygen error for Resident #487. No further information was provided by the facility.

2. For Resident # 41, the facility staff failed to ensure the oxygen tank was not empty on 12/5/2017.

Resident # 41 was a 74-year-old male who was admitted to the facility on 9/29/2011 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 695	Continued From page 26	F 695		

readmitted on 3/17/2016 with diagnoses of but not limited to: Neuromuscular scoliosis occipito atlantis axial region, Neuromuscular scoliosis of thoracic region, Abnormal posture, Gastroesophageal Reflux Disease, Chronic Heart Failure, and Malignant Neoplasm of Prostate.

The most recent Minimum Data Set (MDS) was a quarterly assessment with an Assessment Reference Date (ARD) of 10/11/2017. The MDS coded Resident # 41 with a BIMS (Brief Interview for Mental Status) of 15/15 indicating no cognitive impairment; the resident required extensive assistance of 1 staff person with Activities of Daily Living except for bed mobility and bathing. For Bed mobility, he required extensive assistance of two staff persons and required total assistance of one staff person for bathing; Resident # 41 was coded as frequently incontinent of bowel and bladder.

The Resident Council Group Interview was conducted on 12/5/2017 at 2:00 PM. At the end of the Group Interview, one resident in the Group stated she noticed the night before (12/4/17) that Resident # 41's oxygen tubing had come off and when she told the nurse and the nurse checked it, the oxygen tank was empty. Resident # 41 attended the Group Interview.

The Group Interview ended at 2:55 PM. Resident # 41 was in the Dining Room during the entire Group Interview. He had oxygen tubing via nasal cannula in his nostrils. The surveyor checked Resident # 41's oxygen container after the Group interview was over. The oxygen tank was observed to be in the red zone indicating it was empty. The gauge indicated the oxygen rate was set at 2 liters per minute.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 695	Continued From page 27	F 695		

Observations:
12/05/17 2:00-2.55 PM- Resident # 41 attended the entire Group Interview meeting. He was sitting in his wheelchair with oxygen tubing via nasal cannula.

12/05/17 3:05 PM, The surveyor observed Resident # 41 had Oxygen via nasal cannula set at 2 Liters/min. The Oxygen tank gauge was in the red zone indicating the tank was empty. The Director of Nursing (DON) came to the Dining Room, looked at the oxygen tank, removed the tubing, felt for a flow of air and found no oxygen coming out of tank. The DON stated "the tank is empty. I will change it immediately."

12/05/17 3:10 PM- Oxygen tank was replaced by DON who showed surveyor the tank gauge was then reading the tank was half full. DON removed the tubing from the tank and felt the oxygen coming out of the tank.

12/05/17 3:15 PM-Facility Staff was asked to obtain a Pulse Oximetry reading on Resident # 41. Employee C checked the Pulse Oximetry reading which was "97."

12/05/17 3:30 PM-Interview conducted with DON who stated the nurse assigned to work with Resident # 41 told her "she was going to check the resident's oxygen tank earlier but he was in the Group interview meeting with the surveyor and the nurse did not want to interrupt the meeting." The DON stated the expectation was for nurses to make sure residents receive oxygen as ordered by the physician. The DON also stated the nurses should check the amount of oxygen in the tank prior to a resident attending

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 695	Continued From page 28	F 695		

activities. The surveyor reiterated that any meeting held by a surveyor could be interrupted for Residents to receive care.

12/5/17 at 4:00 PM-Review of the clinical record revealed a Physician's Order for Oxygen at 2 liters continuously via nasal cannula with Oxygen saturation on Oxygen every shift.

12/6/17 at 9:00 AM, Review of the Facility Policy on Oxygen Administration dated October 2017 revealed statements under "Steps in the Procedure"

"...6. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened ...
7. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated."

12/6/2017 at 11:25 AM, Resident # 41 was observed sitting in the dining room with Oxygen via nasal cannula at 2 liters per minute. The portable oxygen tank gauge showed the tank was half full.

During the end of day debriefing on 12/6/17, the Director of Nursing, Administrator and Corporate Consultant were informed of the findings.

No further information was provided.

F 825 SS=D Provide/Obtain Specialized Rehab Services CFR(s): 483.65(a)(1)(2) — F 825

§483.65 Specialized rehabilitative services.
§483.65(a) Provision of services.
If specialized rehabilitative services such as but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 825 Continued From page 29

not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must-

§483.65(a)(1) Provide the required services; or

§483.65(a)(2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act.

This REQUIREMENT is not met as evidenced by:

Based on resident interview, staff interview, and clinical record review, the facility staff failed, for 1 resident (Resident #38) in the survey sample of 22 residents, to provide appropriate equipment to maintain or improve mobility.

The facility staff failed to provide Resident #38 with appropriate equipment to maintain or improve mobility, after her ankle was fractured in 2 places while being transported by staff in a standard wheelchair without leg rests/food petals. Prior to the fracture, Resident #38 was able to use her feet to ambulate independently with a wheelchair.

The Findings included:

Resident #38 was 69 years old when admitted to the facility on 4/29/16. Resident #38's diagnoses included Altered Mental Status, Encephalopathy,

F 825

1-15-18

F825

Corrective Action(s):

Resident #38 has been re-evaluated by Physical therapy and Occupational to determine the proper mobility devices to maintain or improve mobility in her wheelchair. The attending physician has been notified that the facility failed to provide leg rests on resident #38's wheelchair while used for transport. An Incident & Accident form has been completed for this incident.

Identification of Deficient Practices/Corrective Action(s):

All other residents utilizing a wheelchair without leg rests for mobility may have been affected. The therapy department will conduct a 100% audit of all residents using wheelchairs without leg rests to identify residents at risk for impaired mobility related to not using proper leg rests. Any/all negative findings will be corrected at time of discovery. An Incident & Accident form will be completed for each negative finding.

Systemic Change(s):

Facility policy and procedure has been reviewed. No revisions are warranted at this time. All nursing and therapy staff will be inserviced by the therapy manager on the importance assessing and utilizing the proper mobility aides to include leg rests on wheelchairs to maintain and/or improve mobility while in the wheelchair.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 825	Continued From page 30	F 825		

Heart Failure, Hypertension, and Diabetes Mellitus.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 10/12/17, coded Resident #38 as being able to understand and be understood by others. She was also coded as having fluctuating inattention and disorganized thinking. She was coded as requiring the extensive physical assistance of one staff person for locomotion, dressing and personal hygiene.

On 12/5/17 an interview was conducted with Resident #38. She stated, "Aides took me to the beauty parlor to get my hair washed. They said we had to move fast because the the beauty parlor was closing. One aide pushed me fast while the other one walked with us and said to hurry up. I didn't have foot rests. My foot went down and my left ankle broke in 2 places. It happened in the hallway. I screamed, and was sent to the hospital."

On 12/5/17 a review was conducted of Resident #38's clinical record, revealing that on 4/27/16, she sustained a fractured ankle while being transported by staff in a wheelchair without leg rests/ foot petals.

On 12/7/17 at 1:30 P.M. an interview was conducted with Resident #38. Resident #38's wheelchair was next to her bed. It didn't have leg rests/ foot petals. There were no leg rests/ foot petals in her closet. According to the clinical record, and the statement by Resident #38, prior to the ankle fracture, she used her feet to ambulate around the facility in her wheelchair. After the fracture, Resident #38 had spent the

Monitoring:
The Therapy Manager is responsible for maintaining compliance. The therapy department will review resident's mobility status and mobility aides quarterly coinciding with the Care plan calendar to ensure proper mobility aides are in place to maintain/improve mobility status. Findings for these reviews will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, an/or practice.
Completion Date: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 825	Continued From page 31	F 825		

majority of her time in bed. She stated that staff take her out of her room for showers, and that she doesn't feel safe in the wheelchair without leg rests/foot petals. When asked if the staff had installed leg rests/foot pedals on her wheelchair after the fracture, she stated, "They threw something together that was unsteady. They didn't hold my feet properly. They tried to crunch up my foot. The pedal was wobbly. My feet would just slip right off the pedals. When they put me in the wheelchair, I could feel myself leaning forward at the gap between my lower back and the back of the wheelchair. I would always slide forward I was sometimes afraid of falling out."

On 12/7/17 a review of Resident #38's clinical record was conducted. The Care Plan read, "7/3/17. Requires extensive assist/total assistance with ADL (Activities of Daily Living) care. Prefers to stay in bed majority of the time. Will attend at least 2 out of room activities of interest through next review."

On 12/7/17 at 1:30 P.M. an interview was conducted with the Director of Rehabilitation (Employee F). When asked why Resident #38 did not have a safe form of transport, the Director of Rehabilitation stated that Resident #38 had refused to get out of bed. When asked if Resident #38's wheelchair had been in altered, or adapted or adjusted in any manner since the ankle fracture occurred, she stated, "No." The Director of Nursing was also present (DON -Administration B). They both agreed that Resident #38 is taken via her wheelchair twice weekly for showers, and to have her hair washed. They both were unable to state a specific plan to ensure a safe form of transport to engage in activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 825	Continued From page 32 On 12/7/17, the Administrator was informed of the findings. No further information was received.	F 825		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880	**F880** **Corrective Action(s):** LPN A, C, F, RN B & Employee C have had their finger nails trimmed to a short neat length. The employees involved have been inserviced on maintaining their finger nails in a short neat length to prevent the spread of infection. An Incident & Accident form was completed for each incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All staff has the potential to be affected for having improper finger nail length. The DON, Infection Control Nurse and/or the ADON will review all direct care staff's finger nails to monitor for proper length and neatness. Any negative findings will be addressed corrected at time of discovery. **Systemic Change(s):** The facility policy and procedure for dress code and personal hygiene have been reviewed and revised to indicate the maximum length of finger nails can be is a quarter inch in length. All Nursing Staff will be inserviced on the Dress and personal hygiene policy and issued a copy by the DON and/or Infection Control Nurse.	1-15-18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 880	Continued From page 33	F 880		

reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and
(vi)The hand hygiene procedures to be followed by staff involved in direct resident contact.

§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

§483.80(e) Linens.
Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

§483.80(f) Annual review.
The facility will conduct an annual review of its IPCP and update their program, as necessary.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and facility documentation review, the facility staff failed to implement an effective infection control program.

1. The facility staff failed to assure that fingernails were cut to a short length on five direct care staff.

Monitoring:
The Administrator and DON are responsible for maintaining compliance. The DON, and/or Infection Control Nurse will perform random rounds daily to monitor for nursing staff for compliance. Any negative findings will be addressed at time of discovery and disciplinary action will be taken as warranted. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: January 15, 2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 880	Continued From page 34	F 880		

The findings included:

Licensed Practical Nurse (LPN) F, the Infection Control nurse was observed to have artificial multicolored nails about ½" in length on 12/6/2017 at 1:00 PM.

Employee C, Medical Records, was observed pushing a resident in a wheel chair on 12/6/2017 at 2:30 PM. She was seen to have long natural, unpainted nails approximately ¾" in length.

LPN A was noticed on 12/6/2017 at 2.45PM to have had long blue speckled artificial nails approximately 1" long. She was unable to type in a normal manner, having to use the pads of her fingers to touch the keyboard.

RN B, Director of Nursing was seen to have artificial nails approximately 1/2 "in length on 12/6/2017 at 4:45 PM.

RN C, Assistant Director of Nursing was seen to have painted nails approximately 3/8" long. On 12/6/2017.

LPN F, Infection Control nurse stated that her nails were inappropriate for a healthcare setting.

The facility did not have a policy regulating nail length however there was a statement on page 21 of the Employee Handbook that stated "Hair, beard, and nails must be clean and neatly trimmed. Extreme styles and colors should be avoided".

Guidance was given at www.cdc.gov, "Whether artificial nails contribute to transmission of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495300	A. BUILDING _____ B. WING _____	12/07/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL KING GEORGE	10051 FOXES WAY KING GEORGE, VA 22485

CORRECTED COPY

(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 880	Continued From page 35	F 880		

health-care-associated (HCW) infections is unknown. However, HCWs who wear artificial nails are more likely to harbor gram-negative pathogens on their fingertips than are those who have natural nails, both before and after handwashing (347--349). Whether the length of natural or artificial nails is a substantial risk factor is unknown, because the majority of bacterial growth occurs along the proximal 1 mm (millimeter) of the nail adjacent to subungual skin (345,347,348). Recently, an outbreak of P. aeruginosa in a neonatal intensive care unit was attributed to two nurses (one with long natural nails and one with long artificial nails) who carried the implicated strains of Pseudomonas spp. on their hands (350). Patients were substantially more likely than controls to have been cared for by the two nurses during the exposure period, indicating that colonization of long or artificial nails with Pseudomonas spp. may have contributed to causing the outbreak. Personnel wearing artificial nails also have been epidemiologically implicated in several other outbreaks of infection caused by gram-negative bacilli and yeast (351--353). Although these studies provide evidence that wearing artificial nails poses an infection hazard, additional studies are warranted."

Administration were informed of the findings on 12/8/2017 at 3:00 PM-COMPLAINT RELATED DEFICIENCY