

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 10/04/2017
FORM APPROVED
OMB NO. 0938-0291

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495371	(X) MULTIPLE CONSTRUCTION A. BUREAU _____ E. WING _____	DATE SURVEY COMPLETED 09/27/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK		STREET ADDRESS CITY STATE ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK VA 24147	
EXAMID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION.)	NO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 000 INITIAL COMMENTS

F 000

An unannounced Medicare/Medicaid standard survey was conducted 9/26/17 through 9/27/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this LTC certified bed facility was 195 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents 1 through 18) and 4 closed record reviews (Residents 19 through 22).

F 371 483.50(j)(1)-(3) FOOD PROCURE
SS=O STORE/PREPARE/SERVE - SANITARY

F 371

F 371

Corrective Action(s):

The pans identified during the Kitchen observation were immediately removed from the rack and re-washed and dried appropriately.

Identification of Deficient Practices & Corrective Action(s):

All other residents may have been potentially affected. The Administrator, Food Service Manager, and/or Registered Dietitian will randomly monitor the kitchen preparation area and the cleaning of these areas during and after meals to identify any negative findings. The Food Service manager will monitor the dishwashing area weekly for proper use of dishwashing techniques. Any/all negative findings will be corrected at time of discovery.

Systemic Change(s):

The facility policy & procedure has been reviewed and no changes are warranted at this time. The Registered Dietitian and/or the CDM will inservice all dietary staff on the proper sanitation, storage, cleaning and transportation of dietary products per established policy and procedure. In addition, the inservice will include all aspects of infection & sanitation control measures.

(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.

(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.

(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.

(iii) This provision does not preclude resident's from consuming foods not procured by the facility.

(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.

(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

EXD DATE

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

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CMS INC 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495311	(X) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X) DATE SURVEY COMPLETED 09/27/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	
(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)
F 371	Continued From page 1 visitors to ensure safe and sanitary storage handling and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store, prepare, and serve food in a safe and sanitary manner. The findings include: An initial tour of the kitchen was done on 9/26/17 at 10:05 a.m. The surveyor was accompanied by the certified dietary manager. The surveyor observed multiple pans stacked on a counter space. The pans were stacked on top of one another. The surveyor asked the dietary manager to pick up individual pans from the stack. As she did, water was observed on the next pan below in the stack of pans. The cook removed the pans from the rack and requested they be washed over. On 9/27/17 at 1:06 p.m., the administrator, director of nursing, and the corporate registered nurse were informed of the nesting of the pans. Prior to exit on 9/27/17, no further information was provided to the surveyor related to the kitchen issues.	F 371	Monitoring: The Dietary manager is responsible for maintaining compliance. The Dietary Manager and/or designee will complete weekly audits for monitoring and maintaining infection and sanitation control compliance. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. Completion Date: 10/16/2017
F 508 SS=D	483.50(b)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS	F 508	
	(b) Radiology and other diagnostic services (1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	IDENTIFIER: PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495371	IX. MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	IX. DATE SURVEY COMPLETED 09/27/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL- RICH CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147	

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F 508 Continued From page 2

This REQUIREMENT is not met as evidenced by

Based on staff interview and clinical record review, the facility staff failed to follow physician orders in regards to chest x-rays for 3 of 22 Residents. Residents #10, #13, and #5.

The findings included:

1. For Resident #10, the physician had ordered a 2 view chest x-ray. However, the contracting x-ray company had obtained a 1 view.

The clinical record review revealed that Resident #10 had been admitted to the facility on 12/23/16. Diagnoses included but were not limited to multiple sclerosis, hypertension, depressive disorder, and chronic pain.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/06/17 included a BIMS (brief interview for mental status) summary score of 12 out of a possible 15 points.

The clinical record included a signed physician order dated 06/30/17 that included an order for a CXR (chest x-ray) 2 view.

However, the contracting radiology company had only obtained a one view chest x-ray on 07/01/17.

On 09/26/17 at approximately 4:15 p.m. the DON (director of nursing) was notified that the physician had ordered a 2 view chest x-ray and the contracting radiology company had only obtained a 1 view chest x-ray.

F 508

F508

Corrective Action(s):

Residents #10, #13 & #5's attending physicians have been notified that residents #10, #13 & #5 did not get a 2 view chest x-ray done as ordered by the physician. Only a 1 view chest x-ray was completed. A Facility Incident/Accident form has been completed for each incident.

Identification of Deficient Practice(s) & Corrective Action(s):

All other residents with physician ordered x-rays may have potentially been affected. A 100% audit of resident clinical records for physician ordered x-rays will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. A Risk Management Incident & Accident form will be completed and proper notification made to the resident's attending physician.

Systemic Changes:

The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inservice on the policy and procedure for obtaining resident laboratory tests and x-rays as ordered by the attending physician.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495371	(2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(3) DATE SURVEY COMPLETED 09/27/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK		STREET ADDRESS CITY STATE ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK VA 24147	

(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	ID COMPLETION DATE
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F 508 Continued From page 3

F 508

No further information regarding the chest x ray was shared with the survey team prior to the exit conference.

2. For Resident #13, the physician had ordered a 2 view chest x ray. However, the contracting x ray company had obtained a 1 view.

The clinical record review revealed that Resident #13 had been admitted to the facility on 02/24/16. Diagnoses included but were not limited to hypertension, osteoporosis, depressive disorder, cognitive communication deficit, and muscle weakness.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/12/17 included a BIMS (brief interview for mental status) summary score of 0 out of a possible 15 points.

The clinical record included a signed physician order dated 05/13/17 that included an order for a CXR (chest x ray) 2 view stat to rule out pneumonia.

However, the contracting radiology company had only obtained a one view chest x ray on 05/13/17. The results of this chest x ray revealed that the Resident had a slight right upper lobe infiltrate.

On 09/27/17 at approximately 1:05 p.m., the administrative staff was notified that the physician had ordered a 2 view chest x ray on 05/13/17 and the contracting radiology company had only obtained a 1 view chest x ray.

No further information regarding the chest x ray

Monitoring:

The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Managers will review all X-ray results weekly to ensure that results match physician orders. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice.

Completion Date: 10/16/2017

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 10/04/2017
FORM APPROVED
OMB NO. 0328-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(b)(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49537	(a) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(a) DATE SURVEY COMPLETED 09/27/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL RICH CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK, VA 24147		
(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.)	DATE COMPLETION DATE
F 508	Continued From page 4 was shared with the survey team prior to the exit conference. 2. The facility staff failed to obtain physician ordered 2 view chest x-ray Resident # 5 was admitted to the facility on 9/12/14 with the following diagnosis: dementia, psychosis, chronic kidney disease, high blood pressure, and depression. A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 6/13/17, the facility staff assessed the resident to understand and to usually understand. He was assessed to have a cognitive summary score of 04. On 9/27/17, a review of Resident #5's clinical record revealed that the physician had given an order on 6/29/17 for a chest x-ray 2 views. A review of the chest x-ray report in Resident #5's clinical record revealed the results of a one view report dated 6/30/17. During a meeting with the administrator and the director of nurses the x-ray report was discussed. The administrator stated "I will have to have a talk with the contract radiology." Prior to exit on 9/27/17, no further information was provided by the facility staff.	F 508		

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State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: VA0205	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/27/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL-RICH CREEK		STREET ADDRESS CITY STATE ZIP CODE 120 OLD VIRGINIA AVENUE RICH CREEK VA 24147		
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F 000	Initial Comments	F 000		
	<p>An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 9/26/17 through 9/27/17. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.</p> <p>The census in this 120 certified bed facility was 105 at the time of the survey. The survey sample consisted of 22 current Resident reviews (Residents 1 through 18) and 4 closed record reviews (Residents 19 through 22).</p>			
F 001	Non Compliance	F 001		
	<p>The facility was out of compliance with the following state licensure requirements:</p> <p>This RULE is not met as evidenced by: The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:</p> <p>Dietary and Food Service Program 12 VAC 5-371-340-Cross reference to F-371</p> <p>Diagnostic Services 12 VAC 5-371-310 (A)-Cross reference to F-508</p>			

LABORATORY DIRECTOR'S ORDER PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

2286

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If continuation sheet 1 of 3