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Heritage Hall of Blacksburg • 3610 South Main Street • Blacksburg, VA 24060 • (P) 540.951.7000

June 29, 2017

Center for Quality Health Services & Consumer Protection
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney L. Miller, Long Term Care Supervisor
Richmond, VA 23233-1463

Mr. Miller,

Attached to this cover letter you will find Heritage Hall – Blacksburg's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during our annual survey.

If I can be of further assistance don't hesitate to contact me at (540) 951-7000.

Sincerely;

Paul Poff
Administrator

HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS
Managed by AMERICAN HEALTHCARE, LLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. BUILDING _____ B. WING _____	C 06/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey nwas conducted on 5/30/17 through 6/1/17. Three compliants were also investigated during the survey. Corrections are required for complainance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey report will follow. The census in this 194 bed certified bed facility was 135 at the time of the survey. The survey sample consisted of 21 current Resident Reviews (Resident #'s 1 through 21) and 3 closed record reviews (Resident #'s 22 through 24).	F 000		
F 257 SS=D	483.10(i)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS (i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81 degrees F. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and Resident interview the facility staff failed to ensure comfortable and safe temperature levels in the Sunshine dining room. This affected 1 of 24 Residents, Resident #8. The findings included: For the Sunshine dining room the facility staff failed to maintain a comfortable temperature. Surveyor was observing Residents in the Sunshine dining room on 05/31/17 at approximately 0800, when surveyor heard Resident #8 crying, stating "I'm cold". When	F 257	F257 Corrective Action(s): The Sunshine dining room temperature was adjusted to increase the temperature in the dining room to the appropriate temperature range. Identification of Deficient Practice(s) and Corrective Action(s): All other resident dining areas may have potentially been affected. The Maintenance Director will perform a documented walkthrough inspection of all resident dining areas to ensure the temperature meets the required temperature range. Any/All negative findings will be corrected upon identification and reviewed with the administrator. A facility Incident and Accident form will be completed for each negative finding. Systemic Change(s): The facility policy and procedure for maintaining comfortable and safe temperature levels has been reviewed and no changes are warranted at this time. The maintenance director has read and reviewed the Temperature guidelines in the regulations. Facility administration will conduct rounds of the facility to ensure that a safe and comfortable temperature is being maintained. All negative findings will be reported to the Maintenance Director and the Administrator for immediate correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	6/29/17

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

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F 257	Continued From page 1 surveyor asked Resident #8 if she was alright, Resident #8 again stated "I'm cold". Resident #8 was seated at the dining table, dressed in long sleeve shirt and long pants. Surveyor had maintenance director check the temperature in the room on 05/31/17 at approximately 0820. The temperature in the room was 66 degrees. Maintenance director stated that he would adjust the temperature. Resident #8 was admitted to the facility on 09/16/13 and readmitted on 06/23/15. Diagnoses included but not limited to hypertension, hyperlipidemia, aphasia, dementia, anxiety, and psychotic disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 03/16/17 coded the Resident as having both long and short-term memory impairment and severely impaired skills for decision making in section C, cognitive patterns. The concern of the temperature in the Sunshine dining room was discussed with the administrative team during a meeting on 05/31/17 at approximately 1620. Surveyor had the maintenance director check the temperature in the Sunshine dining room on 06/01/17 at approximately 0830. Temperature at this time was 69.5. No further information was provided prior to exit.	F 257	Monitoring: The Administrator and Maintenance Director are responsible for maintaining compliance. The Administrator and/or Maintenance director will make weekly rounds using the environmental audit tool to monitor for compliance and identify any negative findings. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: July 16, 2017	
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE	F 271		

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F 271	Continued From page 2 (a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 24 residents (Resident #9) had approved physician orders for immediate care when readmitted to the facility from a hospital admission. The findings included: The facility staff failed to ensure readmission orders for Resident #9 were approved by the physician when the resident was readmitted 9/26/16. The clinical record of Resident #9 was reviewed 5/31/17 and 6/1/17. Resident #9 was admitted to the facility 12/17/10 and readmitted 9/26/16 with diagnoses that included but not limited to end stage renal disease (ESRD) on dialysis, cellulitis and abscess of right lower leg, diabetes mellitus, type 2, peripheral neuropathy, Alzheimer's disease, deep vein thrombosis, pulmonary embolism, and hyperlipidemia. Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/9/17 assessed the resident with a cognitive summary score of 9 out of 15. No signs or symptoms of delirium or psychosis. Resident #9 was assessed to have behavioral symptoms not directed toward others 4 to 6 days in the look back period.	F 271	F-271 Corrective Action(s): Resident #9 has had their current medical treatment plan and Medication and Treatment orders reviewed and signed by their attending physician to ensure the accuracy and need to treat the resident's current medical needs. A facility Incident &Accident form was completed for this incident. Identification of Deficient Practice(s) and Corrective Action(s): All new admissions may have potentially been affected. A 100% review of new admissions for the last 30 days will be completed to verify the accuracy of the resident's admissions orders and that they have been approved and signed by the attending physician to ensure they are receiving the necessary care and services to meet their current medical needs by DON and/or designee. All negative findings will be corrected at time of discovery. A facility Incident/Accident form will be completed for each negative finding. Systemic Change(s): The facility Policy and Procedure was reviewed. No changes are warranted at this time. The licensed nursing staff will be inserviced by the DON/ADON on the policy and procedure for reviewing, noting, and obtaining a physicians signature on all admission and readmission orders. Any further incident of this type will result in disciplinary action.	

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F 271	Continued From page 3	F 271	Monitoring: The DON is responsible for compliance. The DON and/or Designee will perform new admission chart audits 24 hours post admission to ensure that admission orders are accurate and reflect the appropriate treatment needed to meet the resident's needs and have the appropriate physician signatures. Any/all discrepancies found in these audits will be corrected at time of discovery and reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: July 16, 2017	

The surveyor reviewed the 9/26/16 readmission orders. The readmission orders had not been noted by the nurse or dated. The physician had initialed the four pages of readmission orders on 10/18 (no year)-22 days after the resident was readmitted. The clinical record also had the form that read "Accepting Hospital History and Physical as required H&P for Nursing Home admission: yes---no----Signature____ date____:" This form was incomplete except for a squiggly mark at the bottom of each page; however, no physician signature, date or physical examination (assessment) was found. The 9/26/16 4:16 p.m. Departmental Note read in part "Called____ (medical doctor other #1) and left message with his nurse that resident had been readmitted. Orders faxed to MD and pharmacy." The clinical record also contained a fax form dated 9/26/16 for Resident #9 that read "Re-admit" and four pages of the readmission orders dated 9/26/16.

The Departmental Notes from 9/26/16 through 9/30/16 were reviewed. There was no indication Resident #9's readmission orders dated 9/26/16 had been approved by the physician. There was no documentation in the Departmental Notes that the physician's nurse had returned the call to the facility with approved readmission orders. The faxed form had been returned with initials. No date was written on the form when returned. The faxed form had no detailed information when the faxed form was sent or returned.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 5/31/17 at 4:20 p.m. and again on 6/1/17 at 10:55 a.m.

The director of nursing informed the surveyor on

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6/1/17 at 7:30 a.m. that the facility could not prove when the faxed form came back from the physician's office with approved orders.

No further information was provided prior to the exit conference on 6/1/17.

F 280 SS=D 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

483.10
(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care.

(ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(iv) The right to receive the services and/or items included in the plan of care.

(v) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must--

F 271

F-280
Corrective Action(s):
Resident 12's comprehensive care plan has been revised to reflect the discontinuation of resident #12's personal alarm. A Facility Incident & Accident Form was completed for this incident.

F 280

Identification of Deficient Practices & Corrective Action(s):
All other residents with personal Alarms may have potentially been affected. A 100% review of all comprehensive care plans for residents with personal alarms will be conducted by the RCC's and/or designee to identify residents at risk. Residents identified at risk will have their comprehensive care plans updated and revised to reflect their currents needs and interventions to meet their resident specific care needs. A facility 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 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 comprehensive plans of care. The Regional Nurse Consultant will provide in-services to the RCC and care plan team on the mandate to develop individualized care plans within 7 days of the completion of a comprehensive assessment and/or revisions to the comprehensive assessment and as indicated with any changes in condition.

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F 280	Continued From page 5 (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (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 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 280	Monitoring: The RCC and DON will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to finalization coinciding with the care plan schedule. 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: July 16, 2017	

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F 280	Continued From page 6	F 280		

(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 to review and revise the comprehensive care plan for 1 of 24 residents (Resident #12).

The findings included:

The facility staff failed to review and revise the current comprehensive care plan to reflect the discontinuation of a personal alarm for Resident #12.

The clinical record of Resident #12 was reviewed 5/31/17. Resident #12 was admitted to the facility 8/19/05 and readmitted 11/23/16 with diagnoses that included but not limited to atherosclerotic heart disease, anxiety, gastroesophageal reflux disease, bipolar disorder, obesity, urinary incontinence, TIA (transient ischemic attacks), hyperlipidemia, chronic obstructive pulmonary disease, dementia without behavioral disturbances, and peripheral vascular disease.

Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/19/17 assessed the resident with a cognitive summary score of 11 out of 15 in Section C Cognitive Patterns. Resident #12 was assessed without signs/symptoms of

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F 280	Continued From page 7	F 280		

delirium, psychosis, or behaviors that affected other. Resident #12 was assessed to require extensive assistance of one person for dressing, personal hygiene, toileting, bed mobility and transfers.

The current comprehensive care plan identified that Resident #12 had ADL (activities of daily living) need/problem with the onset date of 1/17/12 related to unsteady gait secondary to neuropathy. Approaches: 8/23/16 Personal alarm at all times.

The most recent physician order sheet (POS) was signed 5/11/17 and did not include a physician order for a personal alarm.

The surveyor observed Resident #12 in the dining room on 5/31/17 at 7:40 a.m. and again at 8:00 a.m. The surveyor did not observe a personal alarm attached to Resident #12.

The surveyor observed Resident #12 sitting at the nurse's station on 5/31/17 at 1:15 p.m. The surveyor did not observe a personal alarm on Resident #12. The surveyor asked licensed practical nurse #1 to check for the personal alarm placement. L.P.N. #1 checked Resident #12 for the personal alarm and stated he didn't have one. The surveyor reviewed the current comprehensive care plan with L.P.N. #1. and asked who updates the care plan. L.P.N. #1 stated MDS staff were responsible for updating the care plan.

The surveyor informed the corporate registered nurse of the care plan concern on 5/31/17 at 1:15 p.m.

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F 280	Continued From page 8 The surveyor informed the administrative staff of the failure to review and revise the current comprehensive care plan to reflect the discontinuation of the personal alarm for Resident #12 in the end of the day meeting on 5/31/17 at 4:20 p.m. No further information was provided prior to the exit conference on 6/1/17.	F 280		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan,	F 309	F309 Corrective Action(s): Residents #21's attending physician was notified that the facility failed to administer Bactrim DS as ordered by the physician. A facility Incident and Accident form was completed for this incident. Identification of Deficient Practices/Corrective Action(s): All other residents receiving antibiotics may have been potentially affected. The DON and/or designee will conduct a 100% audit of all residents receiving physician ordered antibiotics to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. Systemic Change(s): The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes following and administering antibiotics per physician orders. The ADON will inservice all licensed nursing staff on the procedure for following and administering medications per physician order.	

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F 309	Continued From page 9 and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for medication administration for 1 of 24 residents (Resident #21). The findings included: The facility staff failed to administer the correct amount of antibiotic ordered by the physician for Resident #21. The clinical record of Resident #21 was reviewed 6/1/17. Resident #21 was admitted to the facility 10/20/09 and readmitted 4/15/17 with diagnoses that included but not limited to end stage renal disease with dependence on renal dialysis, pleural effusion, type 2 diabetes mellitus, acute kidney failure, hypothyroidism, sick sinus syndrome, blindness, right eye, pressure ulcer buttock, hyperlipidemia, hypertension, polyneuropathy, and myocardial infarction. Resident #21's 30 day minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/11/17 assessed the resident with a cognitive summary score of 12 out of 15 and without signs or symptoms of delirium, psychosis, or behaviors affecting others.	F 309	Monitoring: The DON will be responsible for maintaining compliance. The DON and/or Designee will audit resident MAR's weekly to monitor for antibiotic compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: July 16, 2017	

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A telephone order dated 5/16/17 read "Bactrim DS (double strength) one by mouth twice a day for 10 days for toe abscess left great toe. D/C (discontinue) Betadine."

The surveyor reviewed the May 2017 electronic medication administration record (eMAR). Entered was the following order "Bactrim DS Tablet 1 tablet by mouth twice daily x 10 days for L great toe abscess Order date: 5/16/17 Start Date: 5/16/17 Stop Date: 5/23/17 Sulfamethoxazole/Trimethoprim 9:00 a.m. and 5:00 p.m." Resident #21 received Bactrim seven (7) days for a total of fourteen doses. Resident #21 did not receive 10 days or 20 doses of the physician ordered antibiotic Bactrim.

The surveyor informed the assistant director of nursing of the above concern on 6/1/17 at 9:40 a.m. The surveyor requested a copy of the May 2017 eMAR.

The assistant director of nursing informed the surveyor on 6/1/17 at 10:00 a.m. that Resident #21 had not received the medication as ordered by the physician.

The surveyor informed the administrative staff of the failure of the facility to administer Bactrim DS as ordered by the physician for 10 days in the end of the day meeting on 6/1/17 at 10:55 a.m.

No further information was provided prior to the exit conference on 6/1/17.

F 323 SS=D 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES — F 323

(d) Accidents.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(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 323	Continued From page 11 The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, staff interview, and clinical record review, the facility staff failed to provide a hazard free environment for 2 of 24 Residents, Residents #17 and #12. The findings included. 1. For Resident #17, the receptacle above the Residents bed was damaged. The clinical record review revealed that Resident #17 had been admitted to the facility 06/25/13. Diagnoses included, but were not limited to,	F 323	F323 Corrective Action(s): The broken electrical receptacle identified in Resident #17's room by the surveyors was replaced by the maintenance director. A facility Incident and Accident form has been completed for this incident. Resident #12's attending physician has been notified that facility staff failed to apply Tubigrip stocking to resident #12's right lower leg. A facility incident and accident form has been completed for this incident. Identification of Deficient Practice(s) & Corrective Action(s): All other resident rooms may have been affected. A 100% review of all resident room receptacles will be conducted to identify potential accident hazard risks and to confirm that all are in proper working order. All negative findings will be corrected at time of discovery and a facility Incident & Accident form will be completed for each incident. All other residents with Tubigrip Stocking orders may have been affected. DON and/or Designee will conduct a 100% review of all Tubigrip orders will be conducted to indentify residents at risk. All negative findings will be corrected at time of discovery and a facility Incident & Accident form will be completed for each negative finding.	

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F 323	Continued From page 12	F 323	Systemic Change(s): All staff will be in serviced by the Maintenance Director regarding the prevention of resident accidents. The inservice will include the proper procedure for listing all needed repairs in the Electronic Work order system at each nurse's station. All nursing staff will be inserviced by ADON on the proper use and application of physician ordered Tubigrip stockings for compression. Monitoring: The Maintenance Director and Environmental Director are responsible for compliance. The Maintenance Director and/or Environmental Director designee will perform daily rounds to ensure there are no potential accident hazards related to broken or exposed electrical receptacles. The Unit Managers are responsible for ensuring Tubigrips and other compression stockings are on residents as ordered. Weekly rounds will be conducted by the Unit Managers to ensure Tubigrips and other physician ordered appliances are applied and worn per physician orders. All negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. Results of the weekly rounds will be reviewed weekly during the Risk Management Committee Meeting. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: July 16, 2017**

dementia, chronic obstructive pulmonary disease, hypertension, and hypothyroidism.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/24/17 included a BIMS (brief interview for mental status) summary score of 0. The Resident had been admitted to hospice care 04/17/17.

On 05/31/17 at approximately 3:30 p.m. while sitting at the nurses station the surveyors were able to observe a handwritten note hanging from the desk that read room ____ (omitted) light socket exposed. Upon entering this room two surveyors were able to visualize that the plug in part of the receptacle above the Residents bed was partially missing.

Upon exiting the room the surveyor asked the staff to call the maintenance director to the unit. Upon his arrival to the unit the surveyor showed him the note. The surveyor and the maintenance director then proceeded to the Residents room. Upon entering the room the maintenance director stated I'm gonna get on that right now.

On 05/31/17 at 3:55 p.m. the maintenance director verbalized to the surveyor that he had fixed the receptacle and it had not been previously reported to him.

The administrative staff was notified of the damaged receptacle in a meeting with the survey team on 05/31/17 at approximately 4:20 p.m.

On 06/01/17 at approximately 11:10 a.m. the surveyor asked the maintenance director what he

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had to do to fix the receptacle. The maintenance director stated he had put a new receptacle in and it looked as though someone had pulled the plug part out of the old one.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to ensure a physician ordered "Tubigrip" stocking had been applied to Resident #12's right lower leg.

The clinical record of Resident #12 was reviewed 5/31/17. Resident #12 was admitted to the facility 8/19/05 and readmitted 11/23/16 with diagnoses that included but not limited to atherosclerotic heart disease, anxiety, gastroesophageal reflux disease, bipolar disorder, obesity, urinary incontinence, TIA (transient ischemic attacks), hyperlipidemia, chronic obstructive pulmonary disease, dementia without behavioral disturbances, and peripheral vascular disease.

Resident #12's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/19/17 assessed the resident with a cognitive summary score of 11 out of 15 in Section C Cognitive Patterns. Resident #12 was assessed without signs/symptoms of delirium, psychosis, or behaviors that affected other.

The current comprehensive care plan identified that Resident #12 had ADL (activities of daily living) need/problem with the onset date of 1/17/12 related to unsteady gait secondary to neuropathy. Approaches: Tubigrips as tolerated.

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The most recent physician order sheet (POS) was signed 5/11/17 and included an order that read "Apply tubigrip Size E 10M to right lower leg each day for compression. May remove at night while in bed. Order date 2/10/17. Start Date 2/10/17."

The surveyor observed Resident #12 sitting at the nurse's station on 5/31/17 at 1:15 p.m. The surveyor asked Resident #12 if he was wearing a stocking on his right leg. Resident #12 stated "Don't have one to put on." The surveyor asked licensed practical nurse #1 to check Resident #12 for application of the tubigrips. L.P.N. #1 stated she had not looked at resident's treatments for the day. L.P.N. #1 was asked if the tubigrips should be applied in the mornings and she stated that they should be. L.P.N. #1 checked Resident #12 for the tubigrips and stated he didn't have one. L.P.N. #1 checked the resident's closet for the tubigrips and found none. L.P.N. #1 stated the tubigrips are similar to TED (support) hose-a compression sock without the foot. L.P.N. #1 stated she would obtain tubigrip stocking from therapy.

The surveyor informed the corporate registered nurse of the above concern on 5/31/17 at 1:15 p.m.

The surveyor informed the administrative staff of the failure to follow the physician order for the use of tubigrips for Resident #12 in the end of the day meeting on 5/31/17 at 4:20 p.m.

No further information was provided prior to the exit conference on 6/1/17.

F 386 483.30(b)(1)-(3) PHYSICIAN VISITS - REVIEW F 386

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F 386 SS=D	Continued From page 15 CARE/NOTES/ORDERS	F 386	F-386 Corrective Action(s): The Attending Physician for residents #9 has been contacted and has seen resident #9 and performed all the requirements for the physician visit. A Facility Incident & Accident form has been completed for this incident. Identification of Deficient Practice(s) and Corrective Action(s): All residents in the facility may have been affected. The DON and/or Designee will conduct a 100% audit of all resident clinical records will be completed to identify residents at risk. All negative findings will be addressed at time of discovery. To include notification to the attending Physician of the tardiness with the resident visits and/or incomplete signing and dating of physician orders and progress notes. A Facility Incident and Accident form will be completed for each incident identified. Systemic Change(s): The facility Policy and Procedure has been reviewed and no changes are warranted at this time. All licensed staff and attending Physicians have been inserviced by ADON and issued a copy of the State and Federal guidelines for Physicians visits and monitoring the residents total plan of care to include writing and dating progress notes at each visit and signing and dating physician orders at each visit if needed. Any physician identified to be out of compliance will be notified by fax and phone of the untimely physician visit. If compliance is not established within 24-hours the Medical Director will be notified of the noncompliance by the attending physician and he will perform the required physician visit.	

(b) Physician Visits
The physician must--

(1) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section;

(2) Write, sign, and date progress notes at each visit; and

(3) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure the physician signed, dated, and wrote a progress note at each physician visit for 1 of 24 residents (Resident #9).

The findings included:

The facility staff failed to ensure Resident #9's physician wrote, signed, and dated progress notes at each visit. There was not an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime.

The clinical record of Resident #9 was reviewed 5/31/17 and 6/1/17. Resident #9 was admitted to the facility 12/17/10 and readmitted 9/26/16 with diagnoses that included but not limited to end stage renal disease (ESRD) on dialysis, cellulitis and abscess of right lower leg, diabetes mellitus,

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F 386	Continued From page 16 type 2, peripheral neuropathy, Alzheimer's disease, deep vein thrombosis, pulmonary embolism, and hyperlipidemia. Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/9/17 assessed the resident with a cognitive summary score of 9 out of 15. No signs or symptoms of delirium or psychosis. Resident #9 was assessed to have behavioral symptoms not directed toward others 4 to 6 days in the look back period. The surveyor reviewed the section of the clinical record where the physician visits were written. An entry read "10/18 Readm (readmission) with initials of attending physician." The entry was not dated with the year and a physician note had not been written. There was not an evaluation of the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical condition. The previous physician visit note was 6/29/16. The surveyor informed the administrative staff of the above concern in the end of the day meeting on 5/31/17 at 4:20 p.m. and again on 6/1/17 at 10:55 a.m. No further information was provided prior to the exit conference on 6/1/17.	F 386	Monitoring: The Administrator and DON are responsible for maintaining compliance. A list of required physician visits will be given to the Administrator at the beginning of each month. The DON and/or designee will complete charts audits coinciding with MDS calendar to monitor and maintain compliance. Aggregate findings of these audits will be reported to the Quality Assurance Committee and Corporate Office for review, analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: July 16, 2017	
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after	F 387		

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admission, and at least once every 60 thereafter.

(2) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to ensure physician visits were made timely for 1 of 24 residents in the survey sample. (Resident #13)

The findings included:

Resident #13 was admitted to the facility on 9/29/16 with the following diagnoses of, but not limited to Parkinson's disease, Lyme disease, insomnia and multiple rib fractures. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #13 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

A clinical record review was performed by the surveyor on 5/31/17. At that time, the surveyor noted that a physician progress note was dated for 2/14/17 and the next physician progress note was dated 5/4/17.

The administrative team was notified of the above documented findings on 5/31/17 at 4:20 pm in the conference room by the surveyor.

On 6/1/17 at 9 am, the director of nursing came to the surveyor and stated, "I cannot find any other progress notes other than what you have

F 387 Corrective Action(s):
The Attending Physician for Resident #13 has been contacted regarding their delinquent visits and has been in to see resident #13. A facility Incident and Accident form has been completed for each incident.

Identification of Deficient Practice(s)
Corrective Action(s):
All residents in the facility may have potentially been affected. The DON and/or Designee will conduct a 100% audit of all resident clinical records will be completed to identify residents at risk. All negative findings will be addressed at time of discovery. To include notification to the attending Physicians of the tardiness with the residents visit. A facility Incident & Accident form will be completed for each incident identified.

Systemic Change(s):
The facility policy and procedure was reviewed and no changes are warranted at this time. All attending Physicians will be inserviced by ADON and issued a copy of the State and Federal guidelines for Physicians visits and monitoring the resident's medical plan of care. Any physician identified to be out of compliance will be notified by fax and phone of the untimely physician visit. If compliance is not established within 24-hours the Medical Director will be notified of the noncompliance by the attending physician and he will perform the required physician visit.

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F 387	Continued From page 18 already for this resident." No further information was provided to the surveyor prior to the exit conference on 6/1/17.	F 387	Monitoring: The Administrator and the Director of Nursing are responsible for maintaining compliance. A list of required physician visits will be given to the DON/Administrator at the beginning of each month. The administrator, DON, and/or designee will audits the charts of resident requiring visits for the month to ensure compliance. Aggregate findings of these audits will be reported to the Quality Assurance Committee and Corporate Office for review, analysis and recommendations for change in facility policy, procedure, and/or practice. Completion Date: July 16, 2017	
F 425 SS=D	483.45(a)(b)(1) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medications were available for administration for 1 of 24 residents in the survey sample. (Resident #13) The findings included: Resident #13 was admitted to the facility on 9/29/16 with the following diagnoses of, but not limited to Parkinson's disease, Lyme disease, insomnia and multiple rib fractures. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #13 was also	F 425	F425 Corrective Action(s): Resident #13's attending physician has been notified that the facility failed to ensure that the physician ordered medications Scopolamine, Donepezil and Elavil were available from pharmacy for administration to Resident #13. A facility Incident and Accident form has been completed for this incident. Identification of Deficient Practices & Corrective Action(s): All residents may have potentially been affected. A 100% review of all resident's medication regimes has been conducted by the DON and/or Designee to identify residents at risk. Residents found to be at risk due the medications being unavailable from the pharmacy will be corrected at time of discovery and their attending physicians will be notified. A facility Incident and Accident form has been completed for each.	

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F 425	Continued From page 19 coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene. A clinical record review was performed by the surveyor on 5/31/17. The surveyor also reviewed the MAR (Medication Administration Record) for the month of May, 2017 for Resident #13. The following medications were documented with a "N" under the date of 5/29/17 for the times they were to be given: "Transderm-Scop (Scopolamine) 1.5 mg (milligram) /3 day Apply one patch behind ear every three days ...Donepezil HCL 10 mg Tablet One tablet by mouth once daily at bedtime ...Elavil 25 mg tablet One tablet po (by mouth) every HS (bedtime) ..." The surveyor reviewed the MAR notes which stated for each of the above documented medications " ...ordered from rx (pharmacy) ..." The administrative team was notified of the above documented findings on 5/31/17 at 4:20 pm in the conference room by the surveyor. On 6/1/17 at 9 am, the director of nursing brought to the surveyor a copy of the receipt of when the facility received the medications from the pharmacy. The director of nursing stated, "The Scopolamine patch and Donepezil was delivered to us on 5/30/17 at 11:00 pm and the Elavil was delivered on 5/31/17 at 19:44 (7:44 pm)." No further information was provided to the surveyor prior to the exit conference on 6/1/17.	F 425	Systemic Changes: The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced by ADON on the Policy and Procedure for medication administration to included medications that are unavailable or do not arrive at the facility timely from the pharmacy for administration. The inservice will include the steps the nurses should take should a medication not be delivered timely from the pharmacy. Monitoring: The DON is responsible for maintaining compliance. The DON and/or Designee will conduct weekly audits of resident MAR's each week to confirm the availability of all ordered drugs. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: July 16, 2017**	
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 431		

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F 431	Continued From page 20 them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431	F431 Corrective Action(s): LPN #1 has received one-on-one inservice training by the regional nurse consultant on the Proper Medication Administration Policy to include storing all medications in a locked medication cart when it is not in line of sight or in control of the Licensed Nurse. A facility incident & accident report was completed for this incident. Identification of Deficient Practices & Corrective Action(s): All unit Medication Carts used to store and dispense medications and narcotics during medication passes may have been potentially affected. The DON and/or designee will conduct a 100% review of all licensed nurses during medication passes to identify any medication carts that are left unlocked or unattended during medication passes. Any/all negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each incident identified. Systemic Change(s): Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the ADON and/or regional nurse consultant on the facility policy and procedure for storing medications and biological to include not leaving medications on the medication carts unattended. The Pharmacy consultant will check each medication carts and medication room for improper storage of medications monthly during scheduled visits.	

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F 431	Continued From page 21	F 431	Monitoring: The DON is responsible for maintaining compliance. The DON and/or Designee will perform 2 random weekly audits of the medication carts to monitor for compliance. All discrepancies found in these audits with Medication carts unlocked or with medications unsupervised from a licensed nurse will be corrected at the time of discovery and appropriate disciplinary action taken as warranted. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. Completion Date: July 16, 2017	

(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to store medication during the medication pass and pour observation in a safe and secure manner for 1 of 24 residents in the survey sample. (Resident #15)

The findings included:

Resident #15 was readmitted to the facility on 5/7/16 with the following diagnoses of, but not limited to anemia, high blood pressure, renal insufficiency, hyperlipidemia, aphasia, stroke, anxiety disorder depression and asthma. The resident was coded on the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 4/30/17 as having a BIMS (Brief Interview for Mental Status) score of 6 out of a possible score of 15. Resident #15 was also coded as totally dependent on 2 or more staff members for transfers, dressing and bathing.

During the medication pass and pour observation made by the surveyor on 5/31/17 at 8:25 am, Licensed practical nurse (LPN) #1 left a bottle of Vitamin D3 1000 IU (international units) on top of

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her medication cart in the hallway between resident room numbers of 412 and 414. LPN #1 went into Resident #15's room, turned her back to the medication cart left in the hallway and administered medications to Resident #15 in the resident's room. The medication cart could not be viewed by LPN #1 when she turned her back and gave Resident #15 her medications.

At 9:30 am, the surveyor notified the director of nursing of the above documented findings by the surveyor. The surveyor requested a copy of the facility's policy on medication administration from the director of nursing.

On 5/31/17 at 9:45 am, the surveyor interviewed LPN #1 and notified her of the above documented findings that occurred during the medication pass and pour observation. LPN #1 stated to the surveyor, "I normally put them up when I get the medicine out, but I didn't today."

The administrative team was notified of the above documented findings on 5/31/17 at 4:20 pm in the conference room by the surveyor.

On 6/1/17 at approximately 7:45 am, the director of nursing provided a copy of the facility's policy titled "Administrating Medications" to the surveyor. Under "Policy Interpretation and Implementation" #16, it stated " ...No medications are to be kept on top of the cart ..."

No further information was provided to the surveyor prior to the exit conference on 6/1/17.

F 502 SS=D — 483.50(a)(1) ADMINISTRATION — F 502

(a) Laboratory Services

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F 502	Continued From page 23	F 502	F502 Corrective Action(s): Resident #5's attending physician has been notified that the facility failed to obtain a Phosphorus level as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. Resident #8's attending physician has been notified that the facility failed to obtain a Basic Metabolic Panel (BMP) as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs. Identification of Deficient Practice(s) & Corrective Action(s): All other residents who had physician ordered lab tests may have potentially been affected. The DON and/or Designee will conduct a 100% audit of all resident's lab orders will be completed to identify residents at risk. All negative findings will be corrected at the time of discovery. The attending physicians will be notified of the missing labs and labs not obtained timely. A facility Incident & Accident Form will be completed. Systemic Changes: The facility policy and procedure has been reviewed and no changes are warranted at this time. The laboratory tracking system has been reviewed and implemented to track and validate that required lab work has been completed per physician order and policy and procedure. The ADON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used.	

(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain physician ordered laboratory test for 2 of 24 residents, Residents #5 and #8.

1. For Resident #5 the facility staff failed to obtain a physician ordered laboratory test, phosphorus. Resident #5 was admitted to the facility 7/21/16 and readmitted on 2/9/17 with diagnoses that included but not limited to high blood pressure, diabetes, chronic kidney disease, anxiety, mood disorder, and heart failure.
A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 5/19/17, the facility staff assessed the resident to understand and to be understood. He was assessed to have a cognitive summary score of 07.

On 5/31/17 Resident #5's clinical record was reviewed. A physicians order for lab test to be obtained on 3/15/17 for a hemoglobin, hematocrit, basic metabolic panel and phosphorus was found. The results of the lab test were not found on the clinical record by the surveyor.

LPN #1 was asked by the surveyor if she would help assist in locating the lab test.

On 5/31/17 at 1:50 the director of nurses (DON) provided the surveyor with the results of the BMP the hemoglobin, and hematocrit. However, the

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F 502	Continued From page 24	F 502	Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will complete the Facility Lab audit tool weekly to monitor for compliance. Any negative findings will be reported to the attending physician and disciplinary action will be taken as warranted. 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: July 16, 2017	

DON said the lab did a phenobarbital and a phenytoin levels instead of the phosphorus. The DON was unsure of why the laboratory had run the wrong labs. The facility staff failed to obtain the physician ordered phosphorus test.

During a meeting with the administration staff that included the administrator, assistant administrator director of nurses and the regional director of nurses the phosphorus test not being obtained was discussed.

Prior to exit no further information was provided by the facility staff related to the lab test that was not obtained.
2. The facility staff failed to obtain a physician ordered lab test for Resident #8.

Resident #8 was readmitted to the facility on 6/23/15 with the following diagnoses of, but not limited to high blood pressure, high cholesterol, aphasia, dementia, anxiety disorder and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/16/17, the resident was coded as having problems with short term and long term memory and also being severely impaired in decision making. Resident #8 requires extensive assistance of 1 staff member for dressing and eating and is totally dependent on 2 or more staff members for bathing.

During the clinical record review on 5/31/17, the surveyor noted a physician order on the POS (Plan of Stay) orders for the month of May, 2017 which stated "BMP (Basic Metabolic Panel) q (every) 6 mos (months) (May/Nov)." The surveyor reviewed the clinical record and could not find the BMP results for the month of

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F 502 Continued From page 25

November, 2016 as it had been previously ordered to be obtained.

On 5/31/17 at approximately 12:30 pm, the surveyor notified the director of nursing of the above documented findings. The director of nursing stated "Let me go and see if I can find it for you."

At 1:10 pm, the director of nursing returned to the surveyor and stated "I could not find the results for the BMP that was to be drawn in November."

The administrative team was notified of the above documented findings on 5/31/17 at 4:20 pm in the conference room by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 6/1/17.

F 504 SS=E 483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

(a) Laboratory Services

(2) The facility must-

(i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed to obtain a physician order prior to obtaining a laboratory test for 3 of 24 residents in the survey sample. (Resident's #8, #9 and #5)

F 502

F504
Corrective Action(s):
Resident #8's attending physician has been notified that the facility obtained two Basic Metabolic Panels without a physician order. A facility Incident & Accident form has been completed for this incident.

Resident #9's attending physician has been notified that the facility obtained a Lipid Panel without a physician order. A facility Incident & Accident form has been completed for this incident

F 504

Resident #5's attending physician has been notified that the facility obtained two BMP's, Urinalysis, Hemoglobin, Hematocrit, & Phosphorus level without a physician order. A facility Incident & Accident form has been completed for this incident

Identification of Deficient Practice(s) & Corrective Action(s):
All other residents may have potentially been affected. The DON and/or Designee will conduct a 100% audit of resident clinical records will be completed to identify residents who have had laboratory tests completed without a physician order. All negative findings will be reported to the attending physicians. A Facility Incident & Accident form will be completed for each incident.

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F 504	Continued From page 26	F 504	Systemic Changes: The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced ADON on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will review all lab tests results weekly to ensure that all resident lab tests obtained had an appropriate physician order for the lab tests prior to obtaining. Any negative findings will be reported to the attending physician and the appropriate disciplinary action taken for staff involved. 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: July 16, 2017	

The findings included:

1. The facility staff failed to obtain a physician order prior to obtaining 2 laboratory tests on Resident #8.

Resident #8 was readmitted to the facility on 6/23/15 with the following diagnoses of, but not limited to high blood pressure, high cholesterol, aphasia, dementia, anxiety disorder and psychotic disorder. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/16/17, the resident was coded as having problems with short term and long term memory and also being severely impaired in decision making. Resident #8 requires extensive assistance of 1 staff member for dressing and eating and is totally dependent on 2 or more staff members for bathing.

During the clinical record review on 5/31/17, the surveyor noted results in the clinical record of Resident #8 for 2 BMP (Basic Metabolic Panel) one of which was dated for 1/30/17 and the other was dated 3/23/17. The surveyor could not find physician's orders for these lab tests to be performed on Resident #8.

On 5/31/17 at 12:30 pm, the director of nursing was notified of the above documented findings by the surveyor. The director of nursing stated "Let me go and see if I can locate these orders for you."

At 1:10 pm, the director of nursing returned to the surveyor and stated, "I could not find the orders for thee BMP's that were obtained."

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The administrative team was notified of the above documented findings on 5/31/17 in the conference room by the surveyor.

No further information was provided to the surveyor prior to the exit conference on 6/1/17.
2. The facility staff failed to obtain a physician order prior to obtaining a lipid panel for Resident #9.

The clinical record of Resident #9 was reviewed 5/31/17 and 6/1/17. Resident #9 was admitted to the facility 12/17/10 and readmitted 9/26/16 with diagnoses that included but not limited to end stage renal disease (ESRD) on dialysis, cellulitis and abscess of right lower leg, diabetes mellitus, type 2, peripheral neuropathy, Alzheimer's disease, deep vein thrombosis, pulmonary embolism, and hyperlipidemia.

Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 4/9/17 assessed the resident with a cognitive summary score of 9 out of 15. No signs or symptoms of delirium or psychosis. Resident #9 was assessed to have behavioral symptoms not directed toward others 4 to 6 days in the look back period.

The laboratory section of the clinical record was reviewed. The results of a lipid panel dated 9/8/16 were there. The surveyor was unable to locate the physician order for the laboratory test.

The surveyor informed the administrative staff of the above concern in the end of the day meeting on 5/31/17 at 4:20 p.m.

The director of nursing informed the surveyor on

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6/1/17 at 7:30 a.m. that there was not a physician order for the lipid panel obtained 9/8/16. The original laboratory order for the lipid panel had been discontinued in July 2016 but the laboratory tracking log still had the order for the lipid panel to be obtained.

No further information was provided prior to the exit conference on 6/1/17.

3. For Resident #5 the facility staff failed to obtain physicians orders for laboratory (lab) test.

Resident #5 was admitted to the facility 7/21/16 and readmitted on 2/9/17 with diagnoses that included but not limited to high blood pressure, diabetes, chronic kidney disease, anxiety, mood disorder, and heart failure.
A review of Resident #5's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 5/19/17, the facility staff assessed the resident to understand and to be understood. He was assessed to have a cognitive summary score of 07.

On 5/31/17, Resident #5's clinical record was review. The following lab results were located on the clinical record: for 2/20/17, a BMP, for 3/6/17, a BMP, for 2/22/17, was a urinalysis with reflex and for 3/15/17, a hemoglobin, hematocrit, basic metabolic panel and phosphorus. The surveyor could not locate the orders for the lab test

LPN #1 at 11:00 am was asked by the surveyor if she would help assist in locating the orders for the lab test.

On 5/31/17 at 1:50 pm, the director of nurses (DON) informed the surveyor that she could not

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F 504	Continued From page 29 find the physician orders for the dates of the lab test 2/20/17, 2/22/17, and 3/6/17. For 3/1 5/17 the DON said the lab did a phenobarbital and a phenytoin levels instead of the phosphorus. The facility failed to obtain the phosphorus. During a meeting with the administration staff that included the administrator, assistant administrator director of nurses and the regional director of nurses the lab test was discussed. Prior to exit no further information was provided by the facility staff related to the labs without an order to the surveyor.	F 504		
F 507 SS=D	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure laboratory tests were filed in the clinical record for 1 of 24 residents in the survey sample. (Resident #13) The findings included: Resident #13 was admitted to the facility on 9/29/16 with the following diagnoses of, but not limited to Parkinson's disease, Lyme disease,	F 507	F507 Corrective Action(s): Resident #13's attending physician has been notified that the results of a physician ordered Laboratory Tests were not available on the resident medical record. A Facility Incident & Accident form has been completed for missing laboratory test results. Identification of Deficient Practices & Corrective Action(s): All other residents with physician ordered laboratory results may have potentially been affected. A 100% review of all resident medical records will be conducted by the DON and/or designee to identify residents at risk.A Risk Management Incident & Accident Report will be completed for each negative finding.	

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insomnia and multiple rib fractures. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/22/17, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 11 out of a possible score of 15. Resident #13 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene.

A clinical record review was performed by the surveyor on 5/31/17 and the following laboratory tests were ordered by the physician on 12/13/17: Vitamin B12, Folic Acid, Homocysteine Methymalonic Acid, CPK, Free Kappa and Lambda Light Chain Total plus ratio, Q969 Acethylcholine Receptor Antibodies binding, blocking and modulating, Anti MUSK Antibodies, BUN/Creatinine, Paraneoplastic Neuropathy Profile, Neurosensory, Q1062 (Yo Hh Ri), SPEP-Protein Electrophoresis with interpretation , ...Reflex of IFE G553 and TSH. The surveyor could not find the results of these laboratory tests in the clinical record.

The surveyor notified Licensed Practical Nurse (LPN) #1 of the above documented findings on 5/31/17 bat 11:00 am in the nurses' station on Unit 4. LPN #1 stated that she would look for these results.

At 2 pm, LPN #1 came to the surveyor with copies of the results of the laboratory test that were not in the clinical record of Resident #13. The surveyor asked where she was able to locate the results and LPN #1 replied, "I had to call the lab and they faxed them over to me. I looked in Medical Records and could not find them anywhere in the building."

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced by the ADON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include timely and accurate filing of laboratory Test results according to the acceptable professional standards and practices.

Monitoring:
The DON is responsible for maintaining compliance. The DON, and/or designee will complete lab audits weekly to monitor for complaince. Any/all negative findings will be corrected at time of discovery. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice.
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F 507	Continued From page 31 The administrative team was notified of the above documented findings on 5/31/17 in the conference room by the surveyor. On 6/1/17 at 10 am, the director of nursing came to the surveyor and stated, "The lab results in question for this resident were faxed to the doctor's office and to us on the same day. I have called the doctor's office and asked if they would fax them to us so I could show you that the physician had been notified of the results. So I am still waiting on the doctor's office to do this." No further information was provided to the surveyor prior to the exit conference on 6/1/17.	F 507		
F 508 SS=D	483.50(b)(1) PROVIDE/OBTAIN RADIOLOGY/DIAGNOSTIC SVCS (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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to obtain a chest x ray as ordered by the physician for 1 of 24 Residents, Resident #14. The findings included. The contracting x ray service obtained a one view chest x ray when the order was for a two view. The clinical record review revealed that Resident #14 had been admitted to the facility 04/04/16.	F 508	F508 Corrective Action(s): Resident #14's attending physician has been notified that resident #14 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 this incident. Identification of Deficient Practice(s) & Corrective Action(s): All other residents with physician ordered x-rays and lab work may have potentially been affected. The DON and/or Designee will conduct a 100% audit of resident clinical records for physician ordered laboratory work and 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.	

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HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(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 508	Continued From page 32 Diagnoses included but were not limited to, chronic obstructive pulmonary disease, aortic aneurysm, urinary retention, anxiety, and depressive disorder. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/17/17 was coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. The clinical record included a physician's telephone order dated 02/23/17 for a chest x ray two views stat. The results of the chest x ray indicated that only one view had been obtained. The conclusion read slight left lower lobe pneumonia and mild congestive heart failure worse than 12-21-16. On 05/31/17 at approximately 8:00 a.m. the nurse consultant was notified of the above. On 05/31/17 at approximately 8:30 a.m. the DON (director of nursing) verbalized to the surveyor that only a one view chest x ray had been obtained. The administrative staff was notified of the above in a meeting with the survey team on 05/31/17 at approximately 4:20 p.m. No further information regarding the chest x ray was provided to the survey team prior to the exit conference.	F 508	Systemic Changes: The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced by ADON on the policy and procedure for obtaining resident laboratory tests and x-rays as ordered with the appropriate pre-procedure preparation orders. Monitoring: The DON is responsible for maintaining compliance. The DON and/or Designee will review all physician orders daily and as needed to ensure that physician ordered X-rays and lab work are being obtained and completed for residents as ordered by their attending physician. 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: July 16, 2017	