December 9, 2016

Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Rodney Miller, Long Term Care Supervisor
Richmond, VA 23233

Mr. Miller;

Attached to this cover letter you will find Heritage Hall -- Grundy'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 the annual survey process.

Heritage Hall – Grundy is committed to providing high quality patient care. We appreciate your assistant in this matter.

If I can be of further assistance don't hesitate to contact me at (276) 935-8144.

Sincerely;

Derrick B. Ratliff

Derrick Ratliff
Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	11/17/2016

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

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 11/15/16 through 11/17/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 120 certified bed facility was 111 at the time of the survey. The survey sample consisted of 21 current Resident reviews (Residents #1 through #21) and 4 closed record reviews (Residents #22 through #25).

F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309	**F309** **Corrective Action(s):**	**12-30-16**

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, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review, the facility staff failed to provide services for the highest practicable well-being of 5 of 25 residents (Resident #16, Resident #2, Resident #7, Resident #8, and Resident #5).

The findings included:

1. The facility staff failed to coordinate dialysis services with the dialysis center for Resident #16.

F309
Corrective Action(s):
Residents #16's attending physician was notified that the facility failed to follow written protocols and policies specific for rendering the care of dialysis patients. A facility Incident and Accident form was completed for this incident.

Resident #2's attending physician was notified that the facility staff failed to administer Vitamin B-12 as ordered by the physician. A facility Incident and Accident form was completed for this incident.

Resident #7's attending physician was notified that the facility staff failed to obtain a physician ordered neurology consult per physician order. A facility Incident and Accident form was completed for this incident.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed [signature]	Administrator	12-9-16

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 309	Continued From page 1	F 309	Residents #8's attending physicians was notified that the facility failed to administer or follow the bowel protocol for resident #8 who did not have a bowel movement for 6 days as ordered by the physician. A facility Incident and Accident form was completed for this incident. Residents #5's attending physician was notified that the facility staff failed to assess for signs & symptoms of CHF for resident #5. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

Resident #16 was admitted to the facility on 10/6/16 with diagnoses that included but not limited to end stage renal disease with hemodialysis, hypertension, osteoporosis, hypertension, diabetes mellitus, right hip and knee replacement, dyslipidemia, recurrent urinary tract infections, septic shock, and lower extremity deep vein thrombosis. The resident's record was reviewed on 11/16/16 at 2:40 p.m.

The 30 day MDS (minimum data set assessment) with an assessment reference date (ARD) of 11/4/16 coded the resident with a brief interview for mental status as 15 out of 15. She required the assistance of staff members to accomplish all ADLs (activities of daily living.) The resident was incontinent of bowel and bladder. Under special treatments, Resident #16 was coded for dialysis.

The latest comprehensive care plan was revised on 10/18/16. The plan included that Resident #16 was at risk for complications related to diagnosis of renal failure, receives Nephro liquid, and receives dialysis 3 times weekly. Approaches listed: Be alert for decrease urine output, be alert for edema, be alert for complaints of SOB (shortness of breath), provide dialysis as ordered, medicate as ordered, and monitor labs as ordered.

The surveyor reviewed the current physician's order sheet (POS) for October 2016. The October POS did not contain orders for dialysis. The clinical record did contain individual telephone orders each time Resident #16 was transported to dialysis. The most recent transport was dated 11/16/16. The clinical record also had orders for dialysis on 11/14/16, 11/11/16, 11/9/16,

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F 309	Continued From page 2 11/7/16, 11/4/16, and 11/2/16. The surveyor was unable to locate any dialysis communication sheets from 11/2/16 through 11/16/16. The surveyor requested the assistance of registered nurse #1on 11/16/16 at 2:40 p.m. for location of dialysis communication sheets. R.N. #1 stated there were no dialysis communication sheets. R.N. #1 stated each time Resident #16 goes to dialysis, a face sheet and the medication sheet are sent. R.N. #1 stated very rarely did the facility get anything back from dialysis. R.N. #1 stated sometimes the most recent labs would be returned. R.N. #1 stated sometimes dialysis would call the facility if there were any issues/concerns. R.N. #1 was asked when Resident #16 returned from dialysis if an assessment was done by the nurses. She stated the nurses would document in the nurses notes if there were any concerns/issues with that day's dialysis. The surveyor reviewed the departmental notes from 11/2/16 through 11/16/16. The 11/2/16 2:06 p.m. did document bruit/thrill observed to shunt on RUE (right upper extremity). No pre-weight or blood pressure prior to leaving for dialysis. 11/2/16 11:13 p.m. departmental note read "Late entry for 11-2-16 @1759 (5:39 p.m.) returned from dialysis with new orders." No assessment was done upon return from dialysis. 11/4/16 2:52 p.m. departmental note documented resident out to dialysis. 11/4/16 10:27 p.m. departmental note did document assessment of the shunt. No other assessment was done.	F 309	**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, obtaining, transcribing and completing physician orders, medication orders, treatment orders. To included dialysis monitoring, CHF monitoring, following the bowel protocol and administering medications per physician order. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as performing physician ordered monitoring and follow up per physician orders. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor for 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: 12-30-16**	

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11/7/16 1245 departmental note documented resident out to dialysis.

11/7/16 11:14 p.m. departmental note documented assessment of the shunt. No other assessment was done.

11/9/16 2:44 p.m. departmental note documented transported to dialysis at 1:00 p.m. and the 11/10/16 12:28 a.m. note documented Resident #16 returned at 5:20 p.m. in no distress. No documented assessment of Resident #16's shunt site for signs/symptoms of infection.

11/11/16 1:05 p.m. departmental note documented resident loa (leave of absence) to dialysis. No documented assessment or note when Resident #16 returned from dialysis.

11/14/16 12:44 p.m. departmental note documented Resident #16 loa to dialysis.

No documented note or assessment of Resident #16 when the resident returned from dialysis on 11/14/16.

The surveyor informed the director of nursing, the assistant director of nursing, and the corporate registered nurse of the above concern on 11/17/16 at 8:00 a.m. and requested Resident #16's November 2016 treatment administration record.

The DON stated Resident #16's post dialysis assessment was not documented each time in the nurse's notes.

The surveyor was unable to locate physician

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orders for assessment of the resident before or after hemodialysis, or for assessment, care, or precautions related to the hemodialysis access site.
The resident's care plan did not list the standard precaution with assess thrill/bruit (of shunt) to avoid needle sticks and blood pressures in the affected arm. The care plan did not address the resident's need for dialysis access site monitoring.

During a summary meeting on 11/17/16 at 9:35 a.m., the administrator, director of nursing, assistant director of nursing, corporate registered nurse and assistant administrator were informed of the concern that facility staff failed to regularly assess the resident's status and the status of the hemodialysis access site before and after hemodialysis and to communicate about the resident's status and condition with the dialysis center after dialysis. The surveyor requested the facility contract with the dialysis center.

The Out-Patient Dialysis Services Agreement signed by both parties on 9/1/1999 contained the following statement, "Center shall provide to the facility information on all aspects of the management of the residents care related to the provision of dialysis services, including directions on management of medical and non-medical emergencies, including, but not limited to, bleeding/hemorrhage, infection/bacteria, septic shock, and care of shunts and fistulas. The Facility will provide for the interchange of information useful or necessary for the care of the resident and will inform the Center of a contact person at the facility whose responsibilities include oversight of provision of dialysis services by BMA (Bio-Medical Applications) and the center

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to the residents of the Facility."

No additional information was provided prior to the exit on 11/17/16.

2. The facility staff failed to follow physician's orders for medication administration for Resident #2. Resident #2 was administered B12 every 2 weeks in November 2016 instead of every month.

The clinical record of Resident #2 was reviewed 11/16/16. Resident #2 was admitted to the facility 12/17/15 with diagnoses that included but not limited to diastolic heart failure, hypertension, sleep apnea, neuromuscular dysfunction of bladder, venous insufficiency, obesity, hyperlipidemia, and shingles.

Resident #2's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/6/16 assessed the resident with a brief interview for mental status as 15 out of 15.

A telephone order dated 10/3/16 read "B12 injection 1000 mcg (micrograms) IM (intramuscular) 1 injection q (every) 2 weeks x 1 month then 1 injection monthly. Recheck B12 monthly x 3 months. Dx (diagnosis): pernicious anemia."

The October 2016 medication administration record (MAR) documented B12 was administered 10/4/16 and 10/18/16. The November 2016 MAR had documentation Resident #2 received Vitamin B12 injections on 11/1/16, 11/4/16, and 11/15/16. Resident #2 received two (2) extra doses of B12 in November 2016.

The surveyor informed the corporate registered

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nurse of the above concern on 11/16/16 at 11:50 a.m. After reviewing October and November 2016 MARs, the corporate registered nurse stated the pharmacy didn ' t change the order.

The surveyor informed the administrator, director of nursing, corporate registered nurse and the assistant administrator of the above finding on 11/16/16 at 3:30 p.m.

No further information was provided prior to the exit conference on 11/17/16.

3. The facility staff failed to obtain a physician ordered neurology consult for Resident #7.

Resident #7 was admitted to the facility on 3/27/15 with the following diagnoses of, but not limited to high blood pressure, Multiple Sclerosis, anxiety disorder, depression and muscle weakness. The resident was coded on the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/2316 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 15 out of a possible score of 15. The resident was also coded as requiring extensive assistance of 2 staff members for personal hygiene and the assistance of 1 staff member for bathing.

The surveyor conducted a clinical record review of Resident #7 ' s chart beginning on 11/16/16. In the physician orders, the surveyor noted an order dated for 10/28/16 which stated, " Schedule (c with a line over it) with neurologist-evaluation MS (Multiple Sclerosis). " The surveyor reviewed the nurses ' notes and noted a note which was dated and timed for 10/28/16 at 6:38 pm which stated, " NO (New Order): schedule with neurologist evaluation MS (Multiple Sclerosis). "

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On 11/17/16 at 8:30 am, LPN (Licensed Practical Nurse) #1 was interviewed by the surveyor at the nurses ' station on B wing. The surveyor asked LPN #1 if a neurologist appointment had been scheduled for Resident #7 and what the date of the appointment was made for. LPN #7 reviewed the physician ' s order dates for 10/28/16 and reviewed the nurses ' notes dated for 10/28/16 through 11/17/16. LPN #1 stated to the surveyor, " I cannot find where this appointment has been made. This is the first time that I have seen this order or even been made aware of the need for this appointment. "

LPN #2 was interviewed by the surveyor on 11/17/16 at 8:45 am in the nurses ' station on B wing. LPN #1 showed LPN #2 the physician order for a neurologist appointment to be made for Resident #7. LPN #2 stated, " This is the first time that I have heard about this. " LPN #2 reviewed the log of physician appointments that had been made for the residents on B wing. LPN #2 stated, " I cannot find where this appointment has been made. "

The surveyor notified the administrative staff of the above documented findings on 11/17/16 at 9:30 am.

No further information was provided to the surveyor prior to the exit conference on 11/17/16.

4. The facility staff failed to follow the bowel protocol for Resident #8.

Resident #8 was admitted to the facility on 10/26/15 with the following diagnoses of, but not limited to high blood pressure, depression,

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Schizophrenia, thyroid disorder and unspecified intellectual disabilities. The resident was coded on the significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/3/16 as having a BIMS (Brief Interview for Mental Status, an assessment tool) score of 9 out of a possible score of 15. Resident #8 was also coded as requiring extensive assistance of 2 staff member for bathing and personal hygiene.

Resident #8 ' s clinical record was reviewed by the surveyor on 11/16/16. The surveyor noted that from 11/7/16 to 11/12/16 the resident did not have a bowel movement documented in the clinical record. The surveyor also noted the physician standing orders for the facility which stated, " Constipation: MOM (Milk of Magnesia) 1 oz. (ounce) Q (every) day PRN (as needed) (Not to exceed 2 days in a row). Dulcolax supp. (suppository) 10 mg (milligram) Q day PRN (Not to exceed 2 days in a row). Fleets enema Q day PRN. "

The director of nursing (DON) was interviewed on 11/16/16 at 11:15 am in the DON ' s office. The DON reviewed the documentation of bowel movements in the electronic clinical record and stated, " The resident did not have a bowel movement from 11/7/16 through 11/12/16. I will have to look to see if any interventions were given to the resident for this. " The surveyor asked the DON for the policy or protocol that the staff was to follow if the resident had not had a bowel movement for 3 days or more.

On 11/16/16 at 3:30 pm, the administrative staff was notified of the above documented findings for Resident #8.

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On 11/17/16 at 7:30 am, the DON provided a copy of the protocol titled " ...Bowel Evacuation Program and Protocol " which stated the following:

" ...Procedure

· Night shift will check bowel movement (BM) or Activities of Daily Living (ADL) sheets-the nurses will be responsible for making sure that the dayshift has a list of anyone not having a BM X (times) 3 days so bowel protocol can be started. The shift nurses will also check the 24-hour report to add to the list anyone who needs next step in the bowel protocol.

· The bowel protocol will be initiated on Day 3 of no Bowel Movement (on the day shift unless the resident wishes to wait until evening shift of that day).

· The standing orders for bowel protocol will be as follows:

1. Milk of Magnesia 1 oz. every day PO (by mouth) prn on day 3 of no bowel movement (BM).
2. Dulcolax Suppository 1 per rectum (PR) prn on day 4 of no bowel movement (BM).
3. Fleets enema 1 per rectum (PR) prn on day 5 of no bowel movement (BM).

· Call medical doctor (MD) if no bowel movement within 24 hours of initiation of above protocol.

· ...Results of intervention will be charted in nurses ' notes and/or appropriate flow sheet. "

The DON also stated " I cannot find any documentation in the nurses ' notes or on the MAR (Medication Administration Record) that any of this was followed by the nursing staff for this resident. "

No further information was provided to the surveyor prior to the exit conference on 11/17/16.

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5. The facility staff failed to assess Resident #5 for signs/symptoms of congestive heart failure.

Resident #5 was admitted to the facility on 1/8/15 with diagnoses of congestive heart failure (CHF), chronic obstructive pulmonary disease,anxiety, diabetes, obstructive sleep apnea, hypertension, gastro-esophageal reflux disease, renal insufficiency , and dementia.

The current quarterly Minimum Data set (MDS) with a reference date of 8/23/16 assessed the resident with a cognitive score of "15" of "15". The resident was assessed requiring supervision of 1 person for bed mobility, transfers, dressing, ambulation, toileting, and bathing, and hygiene.

The clinical record was reviewed. The comprehensive care plan contained a problem the resident was at risk for complications of CHF. The resident received the diuretic medications, Lasix and Aldactone. The interventions included to be alert for edema, complaints of shortness of breath, give medications as ordered , and report any changes to the physician. The care plan also included the resident was on the CHF program with interventions for daily weights.

The clinical record contained the medication administration record (MAR) for November 2016. The daily weights were recorded on the MAR. The resident weighed 215.4 pounds on 11/8 and then 229.5 on 11/9. The resident also weighed 219.5 on 11/13 and 223.4 on 11/14.

The CHF program was reviewed. The program included instructions to be aware of symptoms and seek help for , "weight gain of two to three pounds in a 24 hour period".

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F 309	Continued From page 11 The assistant director of nursing (RN#3) was asked about the CHF program on 11/16/16 at 10:15 a.m. There were no nursing notes the physician had been notified of a weight gain greater than 2-3 pounds in a 24 hour period. The nursing notes did not contain any assessments by the nurse for signs /symptoms of CHF. RN#3 stated the program was new, but the nurses should have assessed the resident. The administrator, director of nursing, and corporate nurse were informed of the findings during a meeting with the survey team on 11/16/16 at 3:30 p.m.	F 309		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 1 of 25 Residents in the sample survey, was free of Significant medication errors, Resident #18. The Findings Included: Resident #18 was a 59 year old female wh0 was admitted on 9/7/16. Admitting diagnoses included, but were not limited to: anemia, coronary artery disease, hypertension, urinary tract infection, diabetes mellitus, arthritis and osteomyelitis. The most current Minimum Data Set (MDS) assessment located in the clinical record was an	F 333	**F333** **Corrective Action(s):** Resident #18's attending physician has been notified that the facility failed to administer Humalog Sliding scale insulin per physician order. The nurse involved in the medication error has received one-on-one inservice training from the DON on the administration of physician ordered medications. A facility Incident & Accident form was completed for each incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents receiving Physician ordered Sliding Scale Insulin may have potentially been affected. A 100% review of all residents with sliding scale insulin orders will be conducted to identify residents at risk. All residents identified at risk will be corrected at time of discovery and appropriate disciplinary action taken. An Incident and Accident form will be completed for each negative finding.	12-30-16

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F 333	Continued From page 12 Admission MDS assessment with an Assessment Reference Date (ARD) of 9/19/16. The facility staff coded that Resident #18 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #18 required limited (2/2) to extensive assistance (3/3) with Activities of Daily Living (ADL's). On November 16, 2016 at 2:45 p.m. the surveyor reviewed Resident #18's clinical record. Review of the clinical record produced the most current signed physician orders dated 11//16. Signed physician orders included, but were not limited to: "Novolog 100 Unit/ML vial FSBS (fasting blood sugar) AC & HS (before meals and at bedtime) with Novolog S/S (sliding scale) as follows: < (less than) 200=0 Units, 201-250=2 Units, 251-300=4 Units, 301-350=6 Units, 351-400=8 Units. Dx (diagnoses): DM (diabetes mellitus) Notify MD if BS (blood sugar) <60 or > (greater than) 400 Generic Aspart." (sic) Continued review of the clinical record produced the November 2016 Medication Administration Records (MAR's). Review of the November 2016 MAR's documented on 11/14/16 at 11:30 a.m. Resident #18's blood sugar was 371. The facility staff documented that 4 Units of Novolog Insulin was administered. The facility staff should have administered 8 Units of Novolog Insulin as ordered by the physician. On November 16, 2016 at 3:15 p.m. the surveyor notified the Director of Nursing (DON) that Resident #18 had physician orders for Sliding Scale Novolog Insulin before meals and at bedtime. The surveyor reviewed the clinical record with the DON. The surveyor pointed out the specific physician order for blood sugars and Sliding Scale Novolog Insulin. The surveyor then reviewed the November 2016 MAR's with the DON. The surveyor pointed out that Resident	F 333	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed staff will be inserviced on the facility policy and procedure by the DON regarding the administration of medications per physician orders to include the proper administration of sliding scale insulin as ordered by the physician. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will do weekly MAR audits to monitor for compliance. Any negative findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these results will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 12-30-16**	

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F 333	Continued From page 13 #18's blood sugar was 371 on 11/14/16 at 111:30 a.m. The surveyor pointed out that the facility staff administered Novolog Insulin 4 Units. The surveyor notified the DON that the physician order ordered for Resident #18 to receive 8 Units of Novolog Insulin for a blood sugar of 351-400. On November 16, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), DON and Corporate Compliance Nurse (CCN). The surveyor notified the Administrative Team (AT) that Resident #18 had physician orders for Novolog Sliding Scale Insulin before meals and at bedtime and that 8 Units was to be administered if the blood sugar was 351-400. The surveyor notified the AT that on 11/14/16 at 11:30 a.m. Resident #18's blood sugar was 371. Resident #18 should have received 8 Units of Novolog Insulin; however, the facility staff administered 4 Units of Insulin. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that Resident #18 was free of significant medication errors.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	**F441** **Corrective Action(s):** The attending physician for resident #9 & #13 was notified that the facility failed to implement appropriate infection control practices for addressing resident #9 & #13's care needs. LPN #1 has been inserviced by the DON on the proper contact isolation procedure to be utilized when assessing and assisting residents on isolation precautions. An Incident & Accident form was completed for each incident.	12-30-16

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F 441	Continued From page 14 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interviews, facility documents and clinical record reviews it was determined the facility staff failed to follow infection control policies for 2 of 25 residents (Residents #13 & #9.) Findings: 1. Resident #13 was re-admitted to the facility on 11/10/16. Her diagnoses included MDRO (multi-drug resistant organisms), emphysema, diabetes, hypertension, atrial fibrillation, and	F 441	**Identification of Deficient Practice(s) & Corrective Action(s):** All residents on isolation may have the potential to be affected by improper use of PPE, hand washing and improper infection control techniques. The DON,ADON and/or Unit Manager will conduct audits on residents on isolation to observe proper infection control practices, proper PPE use and hand washing during resident care. Any negative findings will be addressed immediately and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All nursing staff will be inserviced on the facility policy and procedure on infection control to include the proper use of PPE for residents on isolation by the DON, ADON and/or Regional Nurse consultant. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform random weekly audits of residents on isolation precautions to monitor nursing staff for compliance. Any negative findings will addressed at time of discovery and disciplinary action 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:** 12-30-16	

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depression.

The facility had not completed a comprehensive MDS (minimum data set since she was a new re-admit. Her entry MDS was dated 11/10/16-- but did not contain her functional or cognitive status.

Resident #13's CCP (comprehensive care plan) dated 11/10/16 documented the resident with self-care deficit in toileting and requiring an assist with toileting. "Has diagnosis of MDRO of the urine....." The interventions included: "......Provide gloves gown, mask.....Place sign on door, visitors to report to NS (nurse) before entering room....."

Resident #13's physician orders, signed and dated 11/15/16, included "Provide contact isolation R/T (related to) MDRO of urine."

On 11/15/16 at 2:00 PM, during the initial tour of the facility, two CNAs were observed in Resident #13's room, providing care for both residents housed there. A sign on the wall, next to to the door, instructed visitors to please report to the nurse before entering the room.

RN I was on tour with the surveyor and asked what kind of infection the residents had. RN I said the resident in bed "B" (Resident #13) had an infection in her urine--and was on contact precautions. The resident in bed "A" did not have an infection that she knew of.

CNA I was observed to have on a mask without a face shield and gloves and was attending the resident in bed "A". CNA II did not have on a mask or gloves when approaching Resident #13's bedside. Neither CNA was wearing a gown.

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CNA II pulled the curtain down between the two resident beds. When she re-emerged from behind the curtain--she had on gloves and a mask--without a face shield.

CNAs I & II were interviewed at that time about the PPE (personal protective equipment) that they were supposed to using while in the room. CNA I said they were supposed to wear gowns, gloves and masks when entering the room.

CNA II said she had her gloves and mask in her pocket and had put them on after closing the curtain for Resident #13's privacy. She stated, "We are supposed to wear gowns, gloves and masks when in this room--we just didn't put on the gowns this time."

On 11/16/16 at 10:11 AM the DON was informed of the surveyor's findings. She was asked what the isolation precautions were for Resident #13's room. She stated, "The staff is supposed to wear gloves, gowns and masks with face shields when attending the residents in that room."

The DON said the staff were to wear masks when toileting the resident at her bedside commode--as well as when emptying the toilet. She said this was and added precaution, in case any of the urine was splashed or spilled during care.

The DON provided the facility policy for contact control precautions for the facility. The facility policy titled "Contact Precautions" stated the following:
1. "In addition to wearing gloves under standard precautions, wear gloves when entering the room."

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2. "Wear a disposable gown upon entering the Contact Precautions room...."
3. "In addition to Standard Precautions, put on a mask when entering the room...."

No additional information was provided prior to the survey team exit.

2. For Resident #9 the facility staff failed to implement an effective infection control program to include, posting signage, gowning and donning gloves prior to entering Resident #9's room and failed to dedicate resident care equipment for Resident #9.

Resident #9 was a 62 year old male who was originally admitted on 6/20/14 and readmitted on 11/2/16. Admitting diagnoses included, but were not limited to: anxiety, major depression, hypertension, chronic obstructive pulmonary disease, chronic pain, sacral decubiti, poly arthritis and Multiple Drug Resistant Organisms (MDRO) in the sacral wound.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 9/6/16. The facility staff coded that Resident #9 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #9 was independent (0/0) to requiring extensive assistance (3/2) with Activities of Daily Living (ADL's).

On November 15, 2016 at 1:40 p.m. the surveyor made an initial tour of the facility with a Licensed Practical Nurse (LPN #1). The surveyor observed PPE (personal protective equipment) gloves, gowns and face covers in a three tiered plastic storage container outside of Resident #9's room door. The surveyor asked LPN (#1) what was the tiered plastic container used. LPN (#1)

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stated Resident #9 had MRDO in his sacral wound. The surveyor did not observe any signage alerting staff, residents and visitors of the need to take necessary precautions for contact isolation.

On November 15, 2016 at 3:35 p.m. the surveyor reviewed Resident #9's clinical record. Review of the clinical record produced signed physician orders dated 11/8/16. Signed physician orders included, but were not limited to: "Requires contact isolation precautions related to MDRO of surgical wound." (sic)

On November 15, 2016 at 3:45 p.m. the surveyor notified the Director of Nursing (DON) that Resident #9 was on contact isolation for MDRO and that on initial tour of the facility signage was not posted alerting staff, residents and visitors of necessary contact isolation precautions. The surveyor requested the facility policy and procedure for infection control.

On November 15, 2016 at 4 p.m. the DON hand delivered the policy and procedure titled, "Isolation-Categories of Transmission-Based Precautions." The policy and procedure read in part ...

"Standard Precautions shall be used when caring for residents at all times regardless of their suspected or confirmed infected status. Transmission-Based Precautions shall be used when caring for residents who are documented or suspected to have communicable diseases or infections that can be transmitted to others. ... Contact Precautions ... c. Gloves and Handwashing (1) In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room. (2) While caring for the resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). (3)

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Remove gloves before leaving the room and perform hand hygiene. (4) After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room. d. Gown (1) Wear a disposable gown upon entering the Contact Precautions room or cubicle. (2) After removing the gown, do not allow clothing to contact potentially contaminated surfaces. ... f. Resident-Care Equipment (1) When possible, dedicate the use of non-critical resident-care equipment items such as stethoscope, sphygmomanometer, bedside commode, or electronic thermometer to a single resident (or cohort of residents) to avoid sharing between residents. (2) If use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. G. Signs- The facility will implement a system to alert staff to the type of precaution resident requires. (1) This facility utilizes the follow system for identification of Contact Precautions for staff and visitors: _____. (2) The facility will also ensure that the resident's care plan and care specialist communication system indicates the type of precautions implemented for the resident." (sic)

On November 16, 2016 at 7:45 a.m. the surveyor was observing LPN (#1) during a medication pass and pour observation. LPN (#1_ informed Resident #9 that she needed to get his blood pressure. LPN (#1) walked to the nurses' station and obtained a sphygmomanometer and roll it down the hallway and into Resident #9's room. LPN (#1) did not don a gown or gloves. LPN (#1) obtained Resident #9's blood pressure and took the sphygmomanometer back to the nurses' station and plug it into the wall. LPN (#1) did not clean the sphygmomanometer. LPN (#1)

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F 441	Continued From page 20 then walked back to the medication cart. The surveyor asked LPN (#1) why she did not don a gown and gloves prior to entering Resident #9's room. LPN (#1) stated, "I didn't think." The surveyor also informed LPN (#1) that the sphygmomanometer was not resident dedicated and that LPN (#1) did not clean the sphygmomanometer prior to making it available for other residents use. On November 16, 2016 at 10:15 a.m. the surveyor entered the DON's office and notified the DON and Corporate Compliance Nurse (CCN) that LPN (#1) did not don a gown and gloves prior to entering Resident #9's room. The surveyor also notified the DON and CCN that LPN (#1) did not dedicate the sphygmomanometer nor clean it after using on Resident #9. In fact LPN (#1) did not clean the sphygmomanometer after using the sphygmomanometer on Resident #9 and prior to making the sphygmomanometer available for other residents use. On November 16, 2016 at 3:30 p.m. the survey team met with the Administrator (Adm), Assistant Administrator (AAdm), DON and CCN. The surveyor informed the Administrative Team (AT) that the facility staff failed to implement an effective infection control program for Resident #9. No additional information was provided prior to exiting the facility as to why the facility staff failed to implement an effective infection control program for Resident #9.	F 441		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness	F 502	**F502** 12-30-16 **Corrective Action(s):** Resident #12's attending physician has been notified that the facility failed to obtain a Lithium as ordered by the physician. A Facility Incident & Accident form has been completed for the missing labs.	

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F 502	Continued From page 21 of the services. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to obtain physician ordered laboratory tests for 25 residents in the survey sample (Residents #12, #3). 1. For Resident #12, facility staff failed to obtain a lithium level. Resident #12 was admitted to the facility on 9/23/09 with diagnoses including cerebrovascular accident, hemiplegia, depression, anxiety, and hepatomegaly. On the quarterly minimum data set (MDS) assessment , the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium or psychosis. The resident scored 21/27 for signs of depression. Clinical record review indicated the resident was assessed by psychiatric services on 10/24/16. Medication doses were adjusted and a lithium level was ordered. The resident's order list and medication administration record indicated the medication doses were changed and administered per the new orders. The surveyor was unable to locate results for a 10/24/16 lithium level test. The surveyor notified the director of nursing of the concern on 11/15/16. Nursing staff were unable to locate evidence the test had been done. 2. The facility staff failed to obtain a physician ordered laboratory (lab) test for Resident #3.	F 502	Resident #3's attending physician has been notified that the facility failed to obtain a Hemoglobin level and a Hemocult stool sample 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. 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, labs not obtained timely and labs obtained without a physician order. 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 DON and/or Nurse Consultant will inservice all licensed staff on physician ordered laboratory-testing, protocols, & tracking system used.	

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F 502	Continued From page 22 Resident #3 was admitted to the facility on 10/7/16 with diagnoses of anemia, atrial fibrillation, hypertension, dementia, stroke, gastro-esophageal reflux disease, depression, chronic obstructive pulmonary disease, anxiety, and osteoporosis. The current 14 day Minimum Data Set (MDS) with a reference date of 10/31/16 assessed the resident with short and long term memory deficit. The resident was assessed requiring extensive assistance of 2 persons for bed mobility, transfers, dressing, eating, toileting, bathing , and hygiene. The clinical record was reviewed. The record revealed a physician order dated 11/9/16 to obtain a hemoglobin level on 11/14/16 to assess for anemia. The lab results were reviewed. There was no hemoglobin level obtained on 11/14/16. The facility obtained a lab test for a hemoglobin A1 C instead. The physician also ordered to perform hemoccult x 3 on 11/2/16. The record did not have any results the stool specimens had been obtained and tested as ordered. The assistant director of nursing (RN#3) was asked about the lab results on 11/16/16 at 9:00 a.m. RN#3 stated the labs were not obtained as ordered. The administrator, director of nursing, and corporate nurse were informed of the findings during a meeting with the survey team on 11/16/16 at 3:30 p.m.	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: 12-30-16**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	11/17/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff obtained a laboratory test without a physician order for 1 of 25 residents (Resident #3). The findings include: The facility staff obtained a hemoglobin A1C without a physician order on 11/14/16 for Resident #3. Resident #3 was admitted to the facility on 10/7/16 with diagnoses of anemia, atrial fibrillation, hypertension, dementia, stroke, gastro-esophageal reflux disease, depression, chronic obstructive pulmonary disease, anxiety, and osteoporosis. The current 14 day Minimum Data Set (MDS) with a reference date of 10/31/16 assessed the resident with short and long term memory deficit. The resident was assessed requiring extensive assistance of 2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene. The clinical record was reviewed. The physician had written an order dated 11/9/16 to obtain an hemoglobin level on 11/14/16. The facility staff obtained a hemoglobin A1C instead without an	F 504	**F504** **Corrective Action(s):** Resident #3's attending physician has been notified that the facility obtained a Hemoglobin A1C laboratory test 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. A 100% audit of resident clinical records will be completed to identify residents who may have had laboratory tests completed without a physician order. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A Facility Incident & Accident form will be completed for each incident. **Systemic Changes:** The facility policy and procedure has been reviewed and no changes are warranted at this time. Licensed staff will be inserviced on the policy and procedure for obtaining resident laboratory tests, which includes obtaining a physician order prior to obtaining the lab test.	12-30-16

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F 504	Continued From page 24 order. The assistant director of nursing (RN#3) was asked about the lab results on 11/16/16 at 9:00 a.m. RN#3 stated the hemoglobin A 1 C was obtained by mistake. The administrator, director of nursing, and corporate nurse were informed of the findings during a meeting with the survey team on 11/16/16 at 3:30 p.m.	F 504	**Monitoring:** The DON is responsible for maintaining compliance. The DON or ADON 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: 12-30-16**	