HERITAGE HALL

December 12, 2017

Office of Licensure and Certification
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Kathaleen Creegan-Tedeschi, Long Term Care Director
Richmond, VA 23233

Ms. Creegan-Tedeschi;

Attached to this cover letter you will find Heritage Hall – Nassawadox'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 (757) 442-5600.

Sincerely;

Susan Parks RN, LNHA
Administrator

RECEIVED
DEC 14 2017

9468 Hospital Avenue / P.O. Box 176 / Nassawadox, Virginia 23413 / 757 442-5600 / Fax 757 442-9401

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard was conducted 11/07/17 through 11/09/17. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. Five Complaints were investigated during the survey.

The census in this 145 certified bed facility was 139 at the time of the survey. The survey sample consisted of 29 resident reviews: 22 current residents (Residents #1 through 21 and Resident #29) and 7 closed record reviews (Residents #22 through #28).

F 157 SS=D NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
CFR(s): 483.10(g)(14)

(g)(14) Notification of Changes.

(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-

(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;

(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of

F 157

F-157
Corrective Action(s)
Resident #3's resident representative has been notified that facility staff failed to notify them timely of a vomiting episode that occurred at breakfast on 11/7/17. A Facility Incident & Accident form has been completed for this incident.

Identification of Deficient Practices & Corrective Action(s):
All residents may have potentially been affected. The DON and Unit Manager's will conduct a 100% review of all clinical records for the last 30 days to identify residents who may have had changes in their medical treatment or condition that would have required physician and responsible party notification. An incident & accident form will be completed for all negative findings and will be corrected at time of discovery.

12/24/17

RECEIVED
DEC 14 2017

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 12/13/17

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 157	Continued From page 1	F 157		

treatment due to adverse consequences, or to commence a new form of treatment); or

(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).

(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.

(iii) The facility must also promptly notify the resident and the resident representative, if any, when there is-

(A) A change in room or roommate assignment as specified in §483.10(e)(6); or

(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.

(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).
This REQUIREMENT is not met as evidenced by:
Based on observations, clinical record review, staff and family interview and facility policy review, the facility staff failed to inform Resident Representatives of a change in condition for 1 out of 29 residents (Resident #3) in the survey sample. The facility staff failed to inform Resident #3's Resident Representative of a change in condition.

The findings include:

Systemic Change(s):
The facility policy and procedures have been reviewed and no changes are warranted at this time. The 24 Hour Report and documentation in the medical record will serve as the source document for communicating changes in resident condition/status, refusal of medical care and treatment and proper notification to responsible parties and physicians. Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Notification of Rights & Services and issued a copy of company policy and procedure. The inservice will include staff education on the timeliness of notification to the attending physician and responsible party when changes in treatment or condition occur in order to prevent a delay of services while promoting continuity of care.

Monitoring:
The DON is responsible for maintaining compliance. The DON or Unit Manager will complete weekly chart audits coinciding with the care plan calendar. Any/all negative findings will be corrected at time of discovery. Aggregate findings of these audits will be reported to the QA committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice.
Completion Date: December 24, 2017

12/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 157	Continued From page 2	F 157		

Resident #3 was admitted to the nursing facility on 8/1/11 and readmitted on 12/13/16 with diagnoses that included high blood pressure, Type II diabetes mellitus, metabolic encephalopathy, dementia and dysphagia (swallowing problems).

The most recent Minimum Data Set (MDS) was a quarterly dated 8/25/17 and coded the resident with short and long term memory problems and severely impaired in the skills necessary for daily decision making. Resident #3 was totally dependent on two staff for all activities of daily living (ADL). The resident was assessed with swallowing problems and on a mechanically altered diet.

The person centered care plan dated 8/21/17 identified swallowing problems and the goal of the staff was to ensure the resident had not complications from the identified problem. One of the interventions to implement this goal included a pureed diet fed to the resident by nursing staff.

On 11/7/17 at 12:30 p.m., during the orientation tour, Resident #3 was observed in bed and coughing with abdominal muscle movements. The Certified Nursing Assistant (#4) stated the resident vomited after breakfast and a mobile chest X-ray had been ordered by the charge nurse who was monitoring his condition. On 11/7/17 at 4:00 p.m., the resident was in the same condition as previously observed. The resident's charge nurse, Licensed Practical Nurse #6, stated she was told at shift change the resident was ordered to have a mobile chest X-ray because they as suspicious he may have aspirated after vomiting at breakfast time. She

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 157	Continued From page 3	F 157		

said the chest X-ray was not ordered stat, thus it may be a few hours before the resident received the X-ray, but he was being monitored for decline in physical status.

On 11/7/17 at 4:45 p.m., Resident #3's Resident Representative approached the Charge Nurse, LPN #6, while she was passing medication and said, "What is going on with my Dad, he is not responding to me like yesterday and he doesn't look so good." LPN #6 said, "Weren ' t you called about his vomiting this morning and we ordering a chest X-ray to rule out aspiration pneumonia?" The Resident Representative stated she had not been called and was shocked to see him look the way he looked. LPN #6 apologized and stated she should have been called.

On 11/8/17 at 10:30 a.m., The Director of Nursing (DON) stated it was her expectation that the staff call Resident #3's Resident Representative when the resident vomited and the staff ordered the Chest X-ray to rule of aspiration. Resident #3 was transferred to the local hospital and admitted with a diagnosis of aspiration pneumonia.

On 11/9/17 at 11:45 a.m., an interview was conducted the 7/3 LPN (#7) that was in charge of Resident #3 the day he vomited, 11/7/17. The DON was present during the interview. LPN #7 stated she was going to call the family member after the X-ray results were called to the facility. She stated it would have been best that she called the resident's representative when he vomited and they ordered the X-ray.

On 11/9/17 at 1:45 p.m., during the debriefing, the Administrator was informed of the aforementioned issue. The Administrator stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 157	Continued From page 4 she too expected the 7/3 nurse to have called the Resident's Representative to inform her of the vomiting episode and ordering of the chest X-ray. The facility's policy and procedure titled Change in a Resident's Condition or Status dated 12/2016 indicated it was their policy to "...Notify the resident's representative of changes in the resident's medical/mental condition or status that may not normally resolve itself without intervention by staff or clinical interventions and is not self limiting..."	F 157		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 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	F 280	**F-280** **Corrective Action(s):** Resident #2's comprehensive cares plan has been reviewed and revised to reflect a falls on 9/4/17 and 9/14/17 and the interventions and preventive measures currently in place to prevent falls. A Incident & Accident Form was completed for this incident. 12/24/17 Resident #14's comprehensive care plan meeting has been conducted with resident #14 presence and participation. Her care plan has been reviewed and revised to reflect her current interventions and treatment needs. A Risk Management Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** Any/all residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the MDS department to identify residents at risk for not being invited to care planning and/or not having their care plans reviewed and revised timely. Residents identified at risk will be corrected at time of discovery and a Incident & Accident Form will be completed for each incident identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 280	Continued From page 5 of care.	F 280		

(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--

(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

Systemic Changes:
The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant and/or RCC will provide in-service training to the interdisciplinary care plan team on the mandate that all residents and their resident representatives must be invited to attend the care plan meeting and that the RCC's are responsible for timely review and revisions to the comprehensive care plan must occur as indicated with any changes in condition or treatment.

12/24/17

Monitoring:
The RCC department will be responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans per care plan calendar calendar prior to finalization to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: December 24, 2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 280	Continued From page 6	F 280		

the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan.

(F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.

(iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.
This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interviews, facility documentation review and clinical record review the facility staff failed to update a care plan give a resident the opportunity to participate in her care plan meeting for 2 of 29 residents (Resident #2 and #14) in the survey sample.

1. The facility staff failed to revise Resident #2's comprehensive care plan to include a fall that occurred on 09/04/17 and 09/14/17.

2. The facility staff failed to give Resident #14 the opportunity to participate in her care plan meeting.

The findings included:

1. Resident #2 was admitted to the nursing facility on 03/05/12. Diagnosis for Resident #2 included but not limited to dementia with behavioral disturbances (1).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 280	Continued From page 7	F 280		

The current Minimum Data Set (MDS) a significant change assessment with an Assessment Reference Date (ARD) of 10/13/17 coded the resident with short and long term memory problems and with severe cognitive impairment - never/rarely made decisions. In addition, the MDS coded Resident #2 with total dependence of one with hygiene, bathing and toilet use, extensive assistance of one with transfers, dressing and bed mobility.

Resident #2's clinical record indicated the following:

On 09/04/17 at 4:20 a.m., resident was found in the floor; getting out of bed unassisted. Resident landed on her bottom with legs out before her, sitting in an upright position at the bedside.

On 09/14/17 at 7:10 a.m., resident was sitting on the floor with her back against the bed. Resident reports she slipped down. Denies pain with active range of motion.

The comprehensive care plan was reviewed on 11/08/17, the care plan did not address Resident #2's falls on 09/04/17 and 09/14/17.

An interview was conducted with the MDS Coordinator on 11/08/17 at approximately 11:45 a.m., who stated the nurses was responsible for updating Resident #2's care plan after her fall on 09/04/17 and 09/14/17. The MDS Coordinator proceeded to say, the nurses should update the care plan but it's also discussed during our 24 hours meeting the following morning and if the care plan is not updated then I will update it. The MDS coordinator stated she didn't have time to care plan Resident #2's falls on 09/4/17 or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 280	Continued From page 8	F 280		

09/14/17.

The facility administration was informed of the finding during a briefing on 11/09/17 at approximately 2:00 p.m. The facility did not present any further information about the findings.

Definitions:

1. Dementia with behavioral disturbances is frequently the most challenging manifestations of dementia and are exhibited in almost all people with dementia.
HTTPS://www/plumbed/22644311

2. Resident #14 was admitted to the facility on 04/02/16. Diagnosis for Resident #14 included but not limited to Parkinson's (1) and Hypothyroidism (2). Resident #14 Quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) on 08/16/17 coded Resident #14 with a BIMS score 15 of a possible 15, indicating no memory impairment.

An interview was conducted with Resident #14 on 11/07/17 at approximately 3:40 p.m. The surveyor asked Resident #14, "Are you being invited to attend her care plan meetings (3) on a regular basis." Resident stated, "I've only attended two meetings since I've been here." The resident proceeded to say, "I'm a retired nurse so I really only don't understand how you can have a care plan meeting without inviting the resident to attend."

On 11/08/17 at approximately 12:05 p.m., during an interview with the Social Worker (SW), this surveyor asked, "What is the process for inviting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 280	Continued From page 9	F 280		

residents to attend their care plan meeting" she replied, "I will call the families and invite the residents personally to attend their care plan meeting (3)." The SW stated, "Resident #14's family called and canceled the care plan meeting that was scheduled for August 30, 2017 but another care plan meeting was never rescheduled." The surveyor asked if Resident #14 was informed of the cancellation and if she given the opportunity to have her care plan meeting as scheduled. The SW stated, "No, this is new for me; I walked into a lot after I got her; just trying to catch up but Resident #14 should have been given the opportunity to make her own decision if she wanted to attended her care plan meeting."

An interview was conducted with the Administrator and Director of Nursing (DON) on 11/09/17 at approximately 9:15 a.m., the Administrator stated, "The resident has the right to decide on whether or not she would like to attend her own care plan meeting; she should have been given the option.

The facility administration was informed of the finding during a briefing on 11/09/17 at approximately 2:00 p.m. The facility did not present any further information about the findings.

The facility's policy: Care Plans, Comprehensive Person-Centered (Revised: 12/2016).

Policy Statement:

A comprehensive, person-centered care plan that includes measurable objectives and timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 280	Continued From page 10	F 280		

for each resident.

Policy Interpretation and Implementation

4. Each resident's comprehensive person-centered care plan will be consisted with the resident's rights to participate in the development and implementation of his or her plan of care, including the right to:
-Participate in the planning process.
-Identify individuals or roles to be included.
-Request meetings.
-Request revisions to the plan of care.
-Participate in establishing the expected goals and outcomes of care.
-Participate the determining the type, amount, frequency and duration of care.

5. The resident will be informed of his or her right to participate in his or her treatment.

15. The resident has the right to refuse to participate in the development of his/her.

Definitions:

1. Parkinson's is a slowly progressive degenerative neurological disorder characterized by resting tremor, pill rolling of the fingers, manlike face's, shuffling gait, forward flexion of the trunk, loss of postural reflexes, and muscle rigidity and weakness (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition).

2. Hypothyroidism is a condition characterized by decreased activity of the thyroid gland (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 280	Continued From page 11	F 280		

3. Care Plan Meeting: The nursing home staff will get your health information and review your health condition to prepare your care plan. You (if you're able), your family (with your permission), or someone acting on your behalf has the right to take part in planning your care with the nursing home staff (HTTPS://www/what-medicare-covers/part-a/care-plan-in-nursing-home. html).

F 309 SS=D PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
CFR(s): 483.24, 483.25(k)(l)

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,

F 309

F309
Corrective Action(s):
Residents #22's attending physician was notified that the facility failed to ensure MS contin was available for administration and the facility staff failed to administer Zofran 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 medications may have been potentially affected. The DON, QA nurse and Unit Managers will conduct a 100% audit of all residents MAR's 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 309	Continued From page 12	F 309		

consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(I) 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 observation, resident interview staff interviews, facility documentation and clinical record review, the facility staff failed to follow physician orders for 1 out 29 Residents in the survey sample, (Resident #22).

The facility staff failed to follow the physician orders for the administration of Zofran and MS Contin for (Resident #22).

Resident #22 was originally admitted to the facility 09/08/16. Diagnosis included but not limited to Cancer, (1) and anemia (2).

The current Minimum Data Set (MDS) an admission assessment with an Assessment Reference Date (ARD) of 09/15/16 coded the resident with a 15 out of a possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating no cognitive impairment. In addition, the MDS coded Resident #22 requiring total dependence of one with dressing, hygiene, bathing and toilet use, extensive assistance of one with bed mobility and limited assistance of one with eating for Activities of Daily Living care.

Resident #22's comprehensive care plan

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 medications per physician orders. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering medications per physician order.

Monitoring:
The DON will be responsible for maintaining compliance. The DON, QA nurse and/or Unit Managers will audit resident MAR's weekly 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: December 24, 2017

12/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 309	Continued From page 13	F 309		

documented resident with a stage IV breast cancer - Resident #22 is at risk for excessive weakness, tiredness, weight loss, pain and depression from cancer process. The goal: less than 3 on a 1-10 pain scale by next review. Some of the intervention/approaches to manage goal included: Medication as ordered - report if ineffective.

Review of the current physician orders included but not limited to the following medications for October 2016:

1. MS Contin 60 mg tablet - give 1 tablet by mouth every 12 hours of pain.
2. Xeloda 500 mg tablet - give 4 tablets twice daily x 14 days for Cancer (chemo) - stop date 10/3/16.
3. Zofran 8 mg tablet - give 1 tablet by mouth 30 minutes before each dose of Xeloda - hold on days not receiving Xeloda.

During the review of Resident's Medication Administration Record (MAR) for October 2016 indicated there was a missed doses MS Contin and the medication Zofran was administered when the order reads to hold when Xeloda is not administered.

On 11/08/17 during the review of Resident #22's October 2016, Medication Administration Record (MAR) revealed the medication MS Contin was not administered on 10/14/16 at 9:00 a.m., (medication not available - hard script obtained).

An interview was conducted with DON on 11/08/17 at approximate 4:50 p.m., who stated there's no reason for Resident #22 to run out of her MS Contin. The DON also stated, "The nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 309	Continued From page 14	F 309		

should have call the pharmacy and requested for the medication to come over stat (immediately) which takes about 2-3 hours for delivery.

On 11/08/17 during the review of Resident #22's MAR for October 2106 indicated that resident refused Xeloda on the following days: 10/01/16 at 8:00 p.m., 10/02/16 at 8 a.m. and 8:00 p.m., but did receive the medication Zofran 8 mg even though the order reads to hold when not receiving Xeloda.

An interview was conducted with the Director of Nursing (DON) on 11/8/17 at approximately 6:00 p.m., who stated the Zofran should not have been administered on the days Resident #22 refused the Xeloda. The DON proceeded to say she expects for the nurses to follow physician orders as prescribed.

An interview was conducted with LPN #4 on 11/09/17 at approximately 12:10 p.m., the surveyor asked, "What is the process for re-ordering controlled pain medications" the LPN stated, "The nurse will check the back of the card, by looking on the back of the narcotic card it will indicate whether or not a hard script is needed or how many refills are still available for reordering." The nurse stated, if the medication is scheduled; we need to make sure there is enough pills so we don't run out; no one should every go without their pain medication especially if they are terminally ill. The LPN also stated, the pharmacy can be called and they will stat over the medication but it a hard script is needed, the doctor will have to come in a write a script for the refill which can cause a delay in receiving the medication.

The facility's Administration was informed of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 309	Continued From page 15	F 309		

findings during a briefing on 11/09/17 at approximately 2:00 p.m. The facility did not present any further information about the findings.

The facilities policy: Administering Medications (Revised December 2012).
Policy Statement: Medications shall be administered in a safe and timely manner, and as prescribed.

Policy Interpretation and Implementation
3. Medications must be administered in accordance with the orders, including and required time frame.
7. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication.

Definitions:
1. Cancer is a neoplasm characterized by the uncontrolled growth of anaplastic cells that tend to invade surrounding tissue and to metastasize to distant body sites (Mosby's Dictionary of Medicine, Nursing & Health Professions, 7th Edition).

2. Anemia is condition when blood does not carry enough oxygen to the rest of your body (Source: NIH U.S. National Library of Medicine <https://www.nlm.nih.gov/?_ga=1.222831837.792012784.1475525034>: Medline Plus).

3. Xeloda is used in combination with other medications to treat breast cancer that has come back after ... has not improved after treatment with other medications

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 309	Continued From page 16 (https://medlineplus.gov/ency/article/007365.htm). 4. MS Contin is used to relieve moderate to severe pain (https://medlineplus.gov/ency/article/007365.htm). 5. Zofran is used to prevent nausea and vomiting caused by cancer chemotherapy, radiation therapy, and surgery (https://medlineplus.gov/ency/article/007365.htm). This is a complaint deficiency.	F 309		
F 314 SS=D	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES CFR(s): 483.25(b)(1) (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility documentation review, clinical record review the facility staff failed to follow	F 314	**F314** **Corrective Action(s):** LPN #3 involved in Resident #8 & 11's treatment observation has been inserviced on proper clean dressing change procedures, hand washing and infection control practices when performing a dressing change for proper infection control and prevention measures to promote healing and prevent infection during pressure ulcer wound care treatment procedures. A facility Incident & Accident form was completed for this incident. 12/24/17 **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with wound care treatments may have been potential affected. The DON, QA nurse and/or Unit Manager will conduct treatment pass audits to monitor for proper dressing change techniques and that infection control practices during pressure ulcer wound care treatments. Any negative findings will be addressed immediately and disciplinary action taken as indicated. A facility Incident and Accident form will be completed each negative finding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 17	F 314		

wound care standard procedures to prevent the potential complications for two Residents (Resident #8 and Resident #11) in the survey sample size of 29.

1. The faciliy staff failed to ensure potential complications were avoided during wound care for Resident #8.

2. The facility staff failed to ensure potential complications were avoided during wound care for Resident #11.

The findings included:

1. Resident #11 was admitted to the facility on 11/11/16. Diagnoses for Resident #11 included but are not limited to Cerebrovascular Accident* (1), Non-Alzheimer's Dementia* (2), and Krauosis Vulvae* (3).

Resident #11's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/18/17 coded Resident #11 with short and long term memory problems with moderate memory impairment.

During an observation on 11/8/17 at approximately 9:45 a.m., of Resident #11's wound care for an Unavoidable Atypical Unstageable Facility Acquired on 7/24/17, Pressure Ulcer* (4). Resident #11 was lying on an air mattress with bilateral heel pressure relief boots on. Licensed Practical Nurse (LPN) #3 began wound care by washing her hands. LPN #3 then sanitized Resident #11's over-bed table. After the table had dried, LPN #3 doffed her gloves and washed her hands. LPN #3, then placed a non-permeable barrier on the table and placed

Systemic Change(s):
The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The licensed nursing staff will be inserviced by the Wound care physician and/or the DON on the facility's Pressure Ulcer Treatment and Prevention Policy and Procedure. Training will include a review of the infection control policy and procedures for providing proper infection control measures during pressure ulcer wound care treatments.

Monitoring:
The DON is responsible for compliance. The wound care physician will review all residents identified with pressure ulcer wounds weekly. The wound care physician will assess and evaluate and document the progression of wound healing weekly. The DON or QA nurse or designee will complete two random treatment pass audits weekly to ensure proper infection control techniques and dressing procedures are being applied to wound care treatments. Any/all negative findings will be addressed at time of discovery. The results of the audits will be sent to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: December 24, 2017

12/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 18	F 314		

her supplies for wound care on the table. LPN #3 used sanitized pointed tip scissors to cut off the soiled dressing from Resident #11's Right ankle. After the soiled dressing was removed, LPN #3 did not remove her gloves and wash hands. LPN #3 using soiled gloves, proceeded to cleanse Resident #3's Right Heel Pressure Ulcer with Dermal Wound Cleanser (DWC). After cleansing the Pressure Ulcer, LPN #3 applied Santyl Ointment to the wound bed, and covered the dressing with calcium alginate dressing and then covered with a sterile dressing and secured with a gauze fluff wrap. The LPN secured the trash, removed her gloves and washed her hands.

Resident #3's Clinical Record documented the following:

11/3/17 Physician Order: Cleanse Right ankle wound with Dermal Wound Cleanser (DWC), pat dry, apply santyl, cover with calcium alginate, cover with dry gauze, wrap with rolled gauze, change QD (daily) and PRN (as needed) if soiled or dislodges.

1/21/17 Physician Order: Multivit-minerals* (5) tablet take one capsule daily supplement

4/21/17 Physician Order: Prostat* (6) 30 milliliters by mouth twice a day

5/20/17 Physician Order: Med Pass* (7) 90 milliliters by mouth every night

6/14/17 Physician Order: Heel Float Boots at all times, Remove during ADL care

7/15/17 Physician Order: Fortified foods on all meal trays

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 19	F 314		

12/12/16 Physician Order: Yogurt with every meal

11/14/16 Physician Order: patient to be fed all meals

Resident #11's Care Plan with the following problem:

11/22/16 Potential for skin breakdown: (Resident #11) will have no skin breakdown through next review due to incontinence and immobility.

Interventions included but were not limited to the following:

Turn or reposition at least every two hours
Treatment orders per physician
Weekly skin assessments
Provide diet as ordered. Record food intake % at each meal.
Report decline in intake to physician
Offer food substitutes if resident refuses to eat
Dietician to evaluate resident nutritional status as ordered
12/22/16 Heel Float Boots while in bed. Remove for Activity of daily living care
Specialty Mattress

The 6/23/16 CNA Care Plan documented the following:

Toileting: Assisted
Bathing: Assisted
Eating/Feeding: Independent
Transfers: One Person Assist
Ambulation: Wheel chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 20	F 314		

Seating: Orthotic Device: Boot Left Ankle/ Wear whenever out of bed

Dietary Note of 11/22/16 documented the following:
" ...been eating 26-100% of meals. Diet is Pureed with honey thickened liquids. Dietary continued to monitor Resident #11 as indicated by Dietary notes: 1/10/17, 1/22/17, 2/17/17, 3/28/17, 4/11/17, 4/21/17, 5/19/17, and 6/27/17.

7/24/17 3:37 p.m. Nursing Note of the Wound Care Nurse LPN #3 documented: "Resident was seen by Dr. (# 5) for new area to Right ankle. Area was cleansed with DWC pat dry and surgically excised of 5.62 centimeters (cm) of devitalized tissue and necrotic subcutaneous fat to a depth of 0.3 cm revealing healthy belled tissue at this time. Santyl ointment was applied to bound bed covered with calcium alginate then covered with dry gauze wrapped with rolled gauze secured with tape at the time ..."

7/24/17 Note of Dr. (#5) documented the following:

Date wound identified: 7/24/17
Location: Right ankle
Stage: Unstageable due to slough/eschar
Drainage: Serous, Small
Measurements:
Length: 2.5 cm
Width: 2.5 cm
Depth: 0.00 cm
Wound Bed: Eschar 90%
Nutritional Review:
Average Breakfast Intake: 50%
Average Lunch Intake: 50%
Average Dinner intake: 75%

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 21	F 314		

Current Weight 181.20 pounds
Admission Weight: 219 pounds

Lab Work:

4/20/17 Prealbumin* (8) 16.8 Low (normal Range mg/dL (milligrams per deci Liter) 18.38)
7/6/17 Hemaglobin* (9) 11.3 Low (normal Range gm/dL (grams per deci Liter) 12 to 16)
10/26/17 Albumin* (10) 2.8 Low (normal Range gm//dL: 3.4 to 4.8)
10/26/17 Hemaglobin 11.4 Low (normal Range gm/dL 12 to 16)

LPN #3 was asked on 11/8/17 at approximately 10:00 a.m., if she had bandage scissors. LPN #3 stated, "Somewhere."

LPN #3 was asked on 11/8/17 at approximately 4:00 p.m. if she should have washed her hands again during wound care of Resident #11. LPN #3 stated that she didn't know and that she had been nervous during the observation. After the surveyor asked if she should have removed her soiled gloves and washed her hands after cleansing the Pressure Ulcer, she stated, "I probably should have." When asked why, LPN #3 stated, "I guess to prevent problems." LPN #3 stated that she found her bandage scissors and by using the sharp tipped scissors she could have cut Resident #3's skin under the dressing.

Doctor (Dr.) #5, the Facility's Wound Care Physician, stated during a phone interview on 11/9/17 at approximately 9:49 a.m. that Resident #3's Right Ankle Pressure ulcer was unavoidable as the skin around the area was very different. She stated that Resident #11's Responsible Party, did not want a biopsy performed or any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 22	F 314		

extensive procedures done due to Resident #11's risk factors.

Doctor (Dr.) #4, the Facility's Palliative Care Physician, stated during an interview on 11/9/17 at approximately 11:15 a.m. that Resident #3 had an Atypical wound, complicated by limited mobility after a Brain Stem Stroke. Dr. #4 stated that Resident #3's skin over the Right ankle had no fatty tissue under the skin that would result in a Pressure Ulcer going from a Stage I to an Unstageable extremely quickly. Dr. #4 also stated that Resident #3's diagnosis of Krauosis Vulvae in addition to Resident #3's immobility contributed to her Unavoidable Pressure Ulcer.

Review of the Facility Policy titled, "Dressings, Dry/Clean with a revision date of 9/2015 documented the following:

Steps in the Procedure:

Clean bedside stand. Establish a clean field.
Place the clean equipment on the clean field.
Wash and dry your hands thoroughly.
Put on clean gloves. Loosen tape and remove soiled dressing.
Pull glove over dressing and discard into plastic or biohazard bag.
Wash and dry your hands thoroughly
Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface.
Label tape or dressing with date, time and initials.
Place on clean field.
Using clean technique, open other products prescribed.
Wash and dry your hands thoroughly.
Put on clean gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 23	F 314		

Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage.
Cleanse the wound with ordered cleanser.
Use dry gauze to pat the wound dry.
Apply the ordered dressing and secure ...per order.
Discard disposable items into the designated container.
Remove disposable gloves and discard into designated container.
Wash and dry your hands thoroughly.
Clean the bedside stand.
Wash and dry your hands thoroughly.

The facility administration was informed of the findings during a briefing on 11/9/17 at approximately
2:02 p.m. The facility did not present any further information about the findings.

DEFINITIONS:

1. Cerebrovascular Accident: (CVA) "Stroke": Medline Plus documented: Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die. There are two kinds of stroke. The more common kind, called ischemic stroke, is caused by a blood clot that blocks or plugs a blood vessel in the brain. The other kind, called hemorrhagic stroke, is caused by a blood vessel that breaks and bleeds into the brain. "Mini-strokes" or transient ischemic attacks (TIAs), occur when the blood supply to the brain is briefly interrupted.

2. Non-Alzheimer's Dementia: Denentia that is not Alzheimer's Disease: Medline Plus documented: Dementia is the name for a group

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 24	F 314		

of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there.

3. Krauosis Vulvae: National Institute of Health documented: a condition that causes the genitals to become raw and itchy, and then shrink.

4. Unstageable Pressure Ulcer: National Pressure Ulcer Advisory Panel documented: Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed

5. Multi vit with Minerals: Medline Plus documented: multi-vitamin with minerals

6. Prostat: Medline documented: a product that delivers high concentration of protein and calories in a low volume

7. Med Pass: Medline documented: Fortified Nutrition provides a convenient way to supplement calories and protein
· Designed to be used as a medication pass drink

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 25	F 314		

8. Pre-albumin: Medline Plus documented: used as a marker of nutritional status.

9. Hemaglobin: Medline Plus documented: A hemoglobin test measures the levels of hemoglobin in your blood. Hemoglobin is a protein in your red blood cells that carries oxygen from your lungs to the rest of your body. If your hemoglobin levels are abnormal, it may be a sign that you have a blood disorder.

10. Albumin: Medline Plus documented: An albumin blood test measures the amount of albumin in your blood. Albumin is a protein made by your liver. Albumin helps keep fluid in your bloodstream so it doesn't leak into other tissues. It is also carries various substances throughout your body, including hormones, vitamins, and enzymes. Low albumin levels can indicate a problem with your liver or kidneys.

2. Resident #8 was admitted originally admitted to the facility on 07/27/15. Diagnosis for Resident #8 included but are not limited to Type 2 Diabetes (1), and a stage IV (2) sacral wound pressure ulcer (3). Resident #8 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/17 coded the resident with a 09 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment. In addition, the MDS coded Resident #8 requiring total dependence of two with toilet use, transfers, dressing, hygiene and bathing, extensive assistance of two with bed mobility and extensive assistance of one with eating. Resident #8 was coded always incontinent of bowel, has indwelling Foley (3).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 26	F 314		

In section "M" (Skin Conditions) of MDS 10/27/17 coded Resident #8 at risk for developing pressure ulcers, having a stage 1 or higher. Resident #8 was coded as having a Stage 3 or 4 pressure ulcer with the following measurements: 8.4 cm x 4.5 cm x 1 cm depth, wound bed with granulation tissue-pink or red tissue with shiny, moist, granular appearance.

Resident #8 revised comprehensive care plan documented Resident #8 with actual skin breakdown to sacrum related to impaired mobility secondary to left and right below knees amputation. The goals: the resident will not develop any new areas of skin breakdown and residents pressure ulcer will exhibit signs of healing as evidenced by decreased in size, improved appearance and be free from signs and symptoms (s/s) of infection.

The current treatment as of 10/31/17 is to cleanse sacrum with Puracyn (wound cleanser), pat dry, apply Santyl (4) then calcium alginate (5) to wound, apply calcium alginate to periwound and cover with padded adhesive dressing daily and as needed.

On 11/08/17 at approximately 10:30 a.m., the resident was observed lying in bed on a specialty mattress; position on his left side. The resident was repositioned remaining on his left. The LPN performed wound care with the assistance of the two CNA's, #7 and 8. The LPN donned a pair of gloves, removed the dressing from the sacral wound, placed the soiled dressing inside a red biohazard bag. The LPN proceeded to clean the wound in a circular motion using Puracyn (wound cleaner), area patted dry, Santyl applied to outer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 27	F 314		

edges of wound bed (slough area) using tongue blade followed with Algicell dressing (6) then covered with Allevyn border (7).

On 11/09/17 at approximately 10:35 a.m., and interview was conducted with LPN who stated, "I should have removed my gloves after I removed the soiled dressing, washed my hands then put on another pair of gloves, cleaned the wound, remove my gloves then wash my hands again."

An interview was conducted with the Director of Nursing (DON) on 11/08/17 at approximately 5:40 p.m., who stated, "The nurse should have washed her hands and put on gloves before wound care was started, after the removal of the soiled dressing her gloves should have been removed, hands washed new gloves applied, cleanse the wound, removed her gloves, washed her hands, put on new gloves then after wound care was finished, gloves removed and hands wash.

The facility administration was informed of the finding during a briefing on 11/09/17 at approximately 2:00 p.m. The facility did not present any further information about the findings.

The facility's policy for Dressings, Dry/Clean (Revised 09/2015).

Purpose: The purpose of this procedure is to provide guidelines for the application of dry, clean dressings. Steps in the Procedure to include but not limited to:

1. Clean beside stand. Establish a clean field.
2. Place the clean equipment on the clean field. Arrange the supplied so they can be easily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 28	F 314		

reached.
3. Tape a biohazard or plastic bag on the bedside stand or use a waste basket below clean field.
4. Position resident and adjust clothing to provide access to affected area.
5. Wash and dry hands thoroughly.
6. Put on clean gloves, loose tape and remove soiled dressing.
7. Pull glove over dressing and discard into plastic or biohazard bag.
8. Wash and dry your hands thoroughly.
9. Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface.

Definitions:

1). Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

2). Pressure Injury - Stage 4 (Full-thickness skin and tissue loss)
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)
.

3). Pressure Injury: A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 29	F 314		

medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/) .

4). Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.

5). Alginate Dressings are composed of calcium alginate, a gelatinous and water-insoluble substance. When in contact with a wound, the calcium alginate in the dressing reacts with sodium chloride from the wound. This turns the dressing into a hydrophilic gel that maintains a moist environment for the wound (www.medicaldepartmentstore.com/Alginate-Dressings-s/286.htm).

6). Algicell dressing manages moderately to heavily exudating wounds (https://www.hightidehealth.com/algicell-ag-alginate-dressing-home.html).

7). Allevyn Dressing allows for the formation and maintenance of a moist wound healing environment, preventing eschar formation and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 314	Continued From page 30 promoting rapid, trouble-free healing (http://www.hightidehealth.com/allevyn-adhesive-foam-dressings-home.html).	F 314		
F 323 SS=D	FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES CFR(s): 483.25(d)(1)(2)(n)(1)-(3) (d) Accidents. 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, facility documentation review, clinical record review the facility staff failed to ensure safety measures to prevent a potential accident of	F 323	**F323** **Corrective Action(s):** LPN #3 involved in Resident #11's treatment observation has been in-serviced on proper clean dressing change procedures to include using Bandage Scissors for removing all dressings and bandages from residents when performing a dressing change to prevent potential injury during wound and skin care procedures. A facility Incident & Accident form was completed for this incident. 12/24/17 **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with wound care treatments may have been potential affected. The DON, QA nurse and/or Unit Manager will conduct treatment pass audits to monitor for proper dressing change techniques and that bandage scissors are used when removing dressings and bandages during pressure ulcer wound and skin care treatments. Any negative findings will be addressed immediately and disciplinary action taken as indicated. A facility Incident and Accident form will be completed for each negative finding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 31	F 323		

cutting a Resident's skin, were utilized when cutting off a soiled dressing using pointed tipped scissors and not bandage scissors for 1 Resident, (Resident #11) in the survey sample size of 29.

The findings included:

Resident #11 was admitted to the facility on 11/11/16. Diagnoses for Resident #11 included but are not limited to Cerebrovascular Accident* (1), Non-Alzheimer's Dementia* (2), and Krauosis Vulvae* (3).

Resident #11's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/18/17 coded Resident #11 with short and long term memory problems with moderate memory impairment.

During an observation on 11/8/17 at approximately 9:45 a.m., of Resident #11's wound care for an Unavoidable Atypical Unstageable Facility Acquired on 7/24/17, Pressure Ulcer* (4). Resident #11 was lying on an air mattress with bilateral heel pressure relief boots on. Licensed Practical Nurse (LPN) #3 began wound care by washing her hands. LPN #3 then sanitized Resident #11's over-bed table. After the table had dried, LPN #3 doffed her gloves and washed her hands. LPN #3, then placed a non-permeable barrier on the table and placed her supplies for wound care on the table. LPN #3 used sanitized pointed tip scissors to cut off the soiled dressing from Resident #11's Right ankle. After the soiled dressing was removed, LPN #3 did not remove her gloves and wash hands. LPN #3 using soiled gloves, proceeded to cleanse Resident #3's Right Heel Pressure Ulcer with

Systemic Change(s):
The facility Policy and Procedure for Wound Care has been reviewed and modified to include bandage scissors as the required equipment to be used during dressing and bandage removal. The licensed nursing staff will be in-serviced by the DON on the facility's Pressure Ulcer and Wound Treatment and Prevention Policy and Procedure. Training will include a review of the procedures and equipment used during pressure ulcer wound care and dressing changes.

Monitoring:
The DON is responsible for compliance. The DON or QA nurse or designee will complete two random treatment pass audits weekly to ensure proper infection control techniques and dressing procedures are being applied to wound care treatments and dressing changes. Any/all negative findings will be addressed at time of discovery. The results of the audits will be sent to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.
Completion Date: December 24, 2017

12/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 32	F 323		

Dermal Wound Cleanser (DWC). After cleansing the Pressure Ulcer, LPN #3 applied Santyl Ointment to the wound bed, and covered the dressing with calcium alginate dressing and then covered with a sterile dressing and secured with a gauze fluff wrap. The LPN secured the trash, removed her gloves and washed her hands.

Resident #3's Clinical Record documented the following:

11/3/17 Physician Order: Cleanse Right ankle wound with Dermal Wound Cleanser (DWC), pat dry, apply santyl, cover with calcium alginate, cover with dry gauze, wrap with rolled gauze, change QD (daily) and PRN (as needed) if soiled or dislodges.

1/21/17 Physician Order: Multivit-minerals* (5) tablet take one capsule daily supplement

4/21/17 Physician Order: Prostat* (6) 30 milliliters by mouth twice a day

5/20/17 Physician Order: Med Pass* (7) 90 milliliters by mouth every night

6/14/17 Physician Order: Heel Float Boots at all times, Remove during ADL care

7/15/17 Physician Order: Fortified foods on all meal trays

12/12/16 Physician Order: Yogurt with every meal

11/14/16 Physician Order: patient to be fed all meals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 33	F 323		

Resident #11's Care Plan with the following problem:

11/22/16 Potential for skin breakdown: Resident #11) will have no skin breakdown through next review due to incontinence and immobility.

Interventions included but were not limited to the following:

Turn or reposition at least every two hours
Treatment orders per physician
Weekly skin assessments
Provide diet as ordered. Record food intake % at each meal.
Report decline in intake to physician
Offer food substitutes if resident refuses to eat
Dietician to evaluate resident nutritional status as ordered
12/22/16 Heel Float Boots while in bed. Remove for Activity of daily living care
Specialty Mattress

Dietary Note of 11/22/16 documented the following:
" ...been eating 26-100% of meals. Diet is Pureed with honey thickened liquids. Dietary continued to monitor Resident #11 as indicated by Dietary notes: 1/10/17, 1/22/17, 2/17/17, 3/28/17, 4/11/17, 4/21/17, 5/19/17, and 6/27/17.

7/24/17 3:37 p.m. Nursing Note of the Wound Care Nurse LPN #3: " ...Resident was seen by Dr. (# 5) for new area to Right ankle. Area was cleansed with DWC pat dry and surgically excised of 5.62 centimeters (cm) of devitalized tissue and necrotic subcutaneous fat to a depth of 0.3 cm revealing healthy belled tissue at this time. Santyl ointment was applied to bound bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 34	F 323		

covered with calcium alginate then covered with dry gauze wrapped with rolled gauze secured with tape at the time ..."

7/24/17 Note of Dr. (#5) documented the following:

Date wound identified: 7/24/17
Location: Right ankle
Stage: Unstageable due to slough/eschar
Drainage: Serous, Small
Measurements:
Length: 2.5 cm
Width: 2.5 cm
Depth: 0.00 cm
Wound Bed: Eschar 90%
Nutritional Review:
Average Breakfast Intake: 50%
Average Lunch Intake: 50%
Average Dinner intake: 75%
Current Weight 181.20 pounds
Admission Weight: 219 pounds

Lab Work:

4/20/17 Prealbumin* (8) 16.8 Low (normal Range mg/dL 18.38)
7/6/17 Hemaglobin* (9) 11.3 Low (normal Range gm/dL 12 to 16)
10/26/17 Albumin* (10) 2.8 Low (normal Range gm//dL: 3.4 to 4.8)
10/26/17 Hemaglobin 11.4 Low (normal Range gm/dL 12 to 16)

LPN #3 was asked on 11/8/17 at approximately 10:00 a.m., if she had bandage scissors. LPN #3 stated, "Somewhere."

LPN #3 stated that she found her bandage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 35	F 323		

scissors and by using the sharp tipped scissors she could have cut Resident #3's skin under the dressing.

The Director of Nursing #2 was asked on 11/8/17 at approximately 4:10 p.m. what type of scissors should be used to cut off a soiled dressing. The Director of Nursing #2 stated that bandage scissors are the correct type of scissors to be used to not potentially cut the patient's skin.

Doctor (Dr.) #5, the Facility's Wound Care Physician, stated during a phone interview on 11/9/17 at approximately 9:49 a.m. that Resident #3's Right Ankle Pressure ulcer was unavoidable as the skin around the area was very different. She stated that Resident #11's Responsible Party, did not want a biopsy performed or any extensive procedures done due to Resident #11's risk factors.

Doctor (Dr.) #4, the Facility's Palliative Care Physician, stated during an interview on 11/9/17 at approximately 11:15 a.m. that Resident #3 had an Atypical wound, complicated by limited mobility after a Brain Stem Stroke. Dr. #4 stated that Resident #3's skin over the Right ankle had no fatty tissue under the skin that would result in a Pressure Ulcer going from a Stage I to an Unstageable extremely quickly. Dr. #4 also stated that Resident #3's diagnosis of Krauosis Vulvae in addition to Resident #3's immobility contributed to her Unavoidable Pressure Ulcer.

The Director of Nursing was asked if the Facility had any policy related to the type of scissors to use during wound care on 11/8/17 at approximately 4:10 p.m. The Director of Nursing stated that there was no specific policy or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 36	F 323		

statement in the wound care policy related to the type of scissors. The Director of Nursing stated, that her expectation for her nursing staff was to utilize bandage scissors so as not to potentially cause any accident potentials.

The facility administration was informed of the findings during a briefing on 11/9/17 at approximately 2:02 p.m. The facility did not present any further information about the findings.

DEFINITIONS:

1. Cerebrovascular Accident: (CVA) "Stroke": Medline Plus documented: Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die. There are two kinds of stroke. The more common kind, called ischemic stroke, is caused by a blood clot that blocks or plugs a blood vessel in the brain. The other kind, called hemorrhagic stroke, is caused by a blood vessel that breaks and bleeds into the brain. "Mini-strokes" or transient ischemic attacks (TIAs), occur when the blood supply to the brain is briefly interrupted.

2. Non-Alzheimer's Dementia: Denentia that is not Alzheimer's Disease: Medline Plus documented: Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there.

3. Krauosis Vulvae: National Institute of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 37	F 323		

documented: a condition that causes the genitals to become raw and itchy, and then shrink.

4. Unstageable Pressure Ulcer: National Pressure Ulcer Advisory Panel documented: Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed

5. Multi vit with Minerals: Medline Plus documented: multi-vitamin with minerals

6. Prostat: Medline documented: a product that delivers high concentration of protein and calories in a low volume

7. Med Pass: Medline documented: Fortified Nutrition provides a convenient way to supplement calories and protein
· Designed to be used as a medication pass drink

8. Pre-albumin: Medline Plus documented: used as a marker of nutritional status.

9. Hemaglobin: Medline Plus documented: A hemoglobin test measures the levels of hemoglobin in your blood. Hemoglobin is a protein in your red blood cells that carries oxygen from your lungs to the rest of your body. If your hemoglobin levels are abnormal, it may be a sign that you have a blood disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 38 10. Albumin: Medline Plus documented: An albumin blood test measures the amount of albumin in your blood. Albumin is a protein made by your liver. Albumin helps keep fluid in your bloodstream so it doesn't leak into other tissues. It is also carries various substances throughout your body, including hormones, vitamins, and enzymes. Low albumin levels can indicate a problem with your liver or kidneys.	F 323		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441	**F441** **Corrective Action(s):** LPN #3 involved in the Treatment Observation for Resident's #8 & #11 has been inserviced one-on-one on proper hand washing and infection control practices to be followed during treatment procedures. A Facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents receiving wound care may have the potential to be affected by improper hand washing and infection control techniques. The DON and/or Unit Manager will conduct a treatment pass audit on LPN #3 to observe proper infection control practices and proper hand washing during the treatment administration procedure. 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.	12/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 39	F 441		

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

(v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and

(vi) The hand hygiene procedures to be followed by staff involved in direct resident contact.

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

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

(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

Systemic Change(s):
The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed staff will be inserviced on the facility policy and procedure for proper hand washing and the infection control policy and procedure by the DON and/or Regional Nurse Consultant.

Monitoring:
The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will perform 2 random weekly Treatment Pass audits to monitor nursing staff for compliance. 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: December 24, 2017

12/24/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 40	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, clinical record review, staff interviews and revised of the facility documentation the facility staff failed to maintain an infection control program to provide a safe, sanitary environment to prevent the development and transmissions of disease and infection for 2 of 29 residents (Resident #8 and 11) in the survey sample.

1. The facility staff failed to implement appropriate hand hygiene during a sacral wound care dressing change for Resident #8.

2. The facility staff failed to implement appropriate hand hygiene during a right ankle care dressing change for Resident #11.

The findings included:

1. Resident #8 was admitted originally admitted to the facility on 7/27/15. Diagnosis for Resident #8 included but are not limited to Type 2 Diabetes (1), and a stage IV (2) sacral wound pressure ulcer (3). Resident #8 Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 10/27/17 coded the resident with a 09 of a total possible score of 15 on the Brief Interview for Mental Status (BIMS), indicating moderate cognitive impairment.

In section "M" (Skin Conditions) of MDS 10/27/17 coded Resident #8 at risk for developing pressure ulcers, having a stage 1 or higher. Resident #8 was coded as having a Stage 3 or 4 pressure ulcer with the following measurements: 8.4 cm x 4.5 cm x 1 cm depth, wound bed with granulation tissue-pink or red tissue with shiny, moist,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 41	F 441		

granular appearance.

Resident #8 revised comprehensive care plan documented Resident #8 with actual skin breakdown to sacrum related to impaired mobility secondary to left and right below knees amputation. The goals: the resident will not develop any new areas of skin breakdown and residents pressure ulcer will exhibit signs of healing as evidenced by decreased in size, improved appearance and be free from signs and symptoms (s/s) of infection.

The current treatment as of 10/31/17 is to cleanse sacrum with Puracyn (wound cleanser), pat dry, apply Santyl (4) then calcium alginate (5) to wound, apply calcium alginate to periwound and cover with padded adhesive dressing daily and as needed.

On 11/08/17 at approximately 10:30 a.m., the resident was observed lying in bed on a specialty mattress; position on his left side. The resident was repositioned remaining on his left side. The LPN performed wound care with the assistance of the two CNA's, #7 and 8.

The LPN removed the dressing from the sacral wound, placed the soiled dressing inside a red biohazard bag. The LPN proceeded to clean the wound with circular motion using Puracyn, area patted dry, Santyl applied to a tongue blade then applied the Santyl to outer edges of wound bed (slough area) followed with Algicell dressing, covered with Allevyn border, gloves removed, hands washed, red bag removed then placed inside red bag located on the side of the treatment cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 42	F 441		

On 11/09/17 at approximately 10:35 a.m., and interview was conducted with LPN #3 who stated, "I should have removed my gloves after I removed the soiled dressing, washed my hands then put on another pair of gloves, cleaned the wound, remove my gloves then wash my hands again."

An interview was conducted with the Director of Nursing (DON) on 11/09/17 at approximately 5:05 p.m., who stated, "The nurse should have washed her hands before wound care was started, after the removal of soiled dressing, after cleaning the wound and again after the dressing change was completed."

The facility administration was informed of the finding during a briefing on 11/09/17 at approximately 2:00 p.m. The facility did not present any further information about the findings.

The facility's policy for Hand/Hand Hygiene (Revised 08/2015).

Purpose: This facility considers hand hygiene the primary means to prevent the spread of infections.

Policy Interpretation and Implementation inciuded but not limited to:

1. All personnel shall be trained and regularly in-serviced on the importance of hand hygiene in preventing the transmission of healthcare-associated infections.

2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 43	F 441		

personnel, residents, and visitors.

7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobal) and water for the following situations:
-Before handling clean or soiled dressings, gauze pads, etc.
-Before moving from a contaminated body site to a clean body site during resident care.
-After contact with blood or bodily fluids.
-After handling used dressings, contaminated equipment, etc.

9. The use of gloves does not replace hand washing/hand hygiene. Integration of gloves use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

Definitions:

1). Diabetes Mellitus Type II is a lifelong (chronic) disease in which there is a high level of sugar (glucose) in the blood (https://medlineplus.gov/ency/article/007365.htm).

2). Pressure Injury - Stage 4 (Full-thickness skin and tissue loss)
Full-thickness skin and tissue loss with exposed or directly palpable fascia, muscle, tendon, ligament, cartilage or bone in the ulcer. Slough and/or eschar may be visible. Epibole (rolled edges), undermining and/or tunneling often occur. Depth varies by anatomical location. If slough or eschar obscures the extent of tissue loss this is an Unstageable Pressure Injury. (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 44	F 441		

3). Pressure Injury:
A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue (http://www.npuap.org/resources/educational-and-clinical-resources/npuap-pressure-injury-stages/)
.

4). Santyl is used to help the healing of burns and ulcers. Collagenase is an enzyme. It works by helping to break up and remove dead skin and tissue. This effect may also help to work better and speed up your body's natural healing process (antibiotics <http://www.webmd.com/cold-and-flu/rm-quiz-antibiotics-myths-facts.

5). Alginate Dressings are composed of calcium alginate, a gelatinous and water-insoluble substance. When in contact with a wound, the calcium alginate in the dressing reacts with sodium chloride from the wound. This turns the dressing into a hydrophilic gel that maintains a moist environment for the wound (www.medicaldepartmentstore.com/Alginate-Dressings-s/286.htm).

6). Algicell dressing manages moderately to heavily exudating wounds

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 45	F 441		

(https://www.hightidehealth.com/algicell-ag-alginate-dressing-home.html).

7). Allevyn Dressing allows for the formation and maintenance of a moist wound healing environment, preventing eschar formation and promoting rapid, trouble-free healing (http://www.hightidehealth.com/allevyn-adhesive-foam-dressings-home.html).

2. Resident #11 was admitted to the facility on 11/11/16. Diagnoses for Resident #11 included but are not limited to Cerebrovascular Accident* (1), Non-Alzheimer's Dementia* (2), and Krauosis Vulvae* (3).

Resident #11's Quarterly Minimum Data Set (an assessment protocol) with an Assessment Reference Date of 7/18/17 coded Resident #11 with short and long term memory problems with moderate memory impairment.

During an observation on 11/8/17 at approximately 9:45 a.m., of Resident #11's wound care for an Unavoidable Atypical Unstageable Facility Acquired on 7/24/17, Pressure Ulcer* (4). Resident #11 was lying on an air mattress with bilateral heel pressure relief boots on. Licensed Practical Nurse (LPN) #3 began wound care by washing her hands. LPN #3 then sanitized Resident #11's over-bed table. After the table had dried, LPN #3 doffed her gloves and washed her hands. LPN #3, then placed a non-permeable barrier on the table and placed her supplies for wound care on the table. LPN #3 used sanitized pointed tip scissors to cut off the soiled dressing from Resident #11's Right ankle. After the soiled dressing was removed, LPN #3 did not remove her gloves and wash hands. LPN

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
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 46	F 441		

#3 using soiled gloves, proceeded to cleanse Resident #3's Right Heel Pressure Ulcer with Dermal Wound Cleanser (DWC). After cleansing the Pressure Ulcer, LPN #3 applied Santyl Ointment to the wound bed, and covered the dressing with calcium alginate dressing and then covered with a sterile dressing and secured with a gauze fluff wrap. The LPN secured the trash, removed her gloves and washed her hands.

Resident #3's Clinical Record documented the following:
11/3/17 Physician Order: Cleanse Right ankle wound with Dermal Wound Cleanser (DWC), pat dry, apply santyl, cover with calcium alginate, cover with dry gauze, wrap with roiled gauze, change QD (daily) and PRN (as needed) if soiled or dislodges.

1/21/17 Physician Order: Multivit-minerals* (5) tablet take one capsule daily supplement
4/21/17 Physician Order: Prostat* (6)* (7) 30 milliliters by mouth twice a day
5/20/17 Physician Order: Med Pass 90 milliliters by mouth every night
6/14/17 Physician Order: Heel Float Boots at all times, Remove during ADL care
7/15/17 Physician Order: Fortified foods on all meal trays
12/12/16 Physician Order: Yogurt with every meal
11/14/16 Physician Order: patient to be fed all meals

Resident #11's Care Plan with the following problem:

11/22/16 Potential for skin breakdown: (Resident #11) will have no skin breakdown through next

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 47	F 441		

review due to incontinence and immobility.

Interventions included but were not limited to the following:

Turn or reposition at least every two hours
Treatment orders per physician
Weekly skin assessments
Provide diet as ordered. Record food intake % at each meal.
Report decline in intake to physician
Offer food substitutes if resident refuses to eat
Dietician to evaluate resident nutritional status as ordered
12/22/16 Heel Float Boots while in bed. Remove for Activity of daily living care
Specialty Mattress

Dietary Note of 11/22/16 documented the following:
" ...been eating 26-100% of meals. Diet is Pureed with honey thickened liquids. Dietary continued to monitor Resident #11 as indicated by Dietary notes: 1/10/17, 1/22/17, 2/17/17, 3/28/17, 4/11/17, 4/21/17, 5/19/17, and 6/27/17.

7/24/17 3:37 p.m. Nursing Note of the Wound Care Nurse LPN #3 documented: " ...Resident was seen by Dr. (# 5) for new area to Right ankle. Area was cleansed with DWC pat dry and surgically excised of 5.62 centimeters (cm) of devitalized tissue and necrotic subcutaneous fat to a depth of 0.3 cm revealing healthy belled tissue at this time. Santyl ointment was applied to bound bed covered with calcium alginate then covered with dry gauze wrapped with rolled gauze secured with tape at the time ..."

7/24/17 Note of Dr. (#5) documented the

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
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 48	F 441		

following:

Date wound identified: 7/24/17
Location: Right ankle
Stage: Unstageable due to slough/eschar
Drainage: Serous, Small
Measurements:
Length: 2.5 cm
Width: 2.5 cm
Depth: 0.00 cm
Wound Bed: Eschar 90%
Nutritional Review:
Average Breakfast Intake: 50%
Average Lunch Intake: 50%
Average Dinner intake: 75%
Current Weight 181.20 pounds
Admission Weight: 219 pounds

Lab Work:
4/20/17 Prealbumin* (8) 16.8 Low (normal Range mg/dL 18.38)
7/6/17 Hemaglobin* (9) 11.3 Low (normal Range gm/dL 12 to 16)
10/26/17 Albumin* (10) 2.8 Low (normal Range gm//dL: 3.4 to 4.8)
10/26/17 Hemaglobin 11.4 Low (normal Range gm/dL 12 to 16)

LPN #3 was asked on 11/8/17 at approximately 10:00 a.m., if she had bandage scissors. LPN #3 stated, "Somewhere."

LPN #3 was asked on 11/8/17 at approximately 4:00 p.m. if she should have washed her hands again during wound care of Resident #11. LPN #3 stated that she didn't know and that she had been nervous during the observation. After the surveyor asked if she should have removed her soiled gloves and washed her hands after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 49	F 441		

cleansing the Pressure Ulcer, she stated, "I probably should have." When asked why, LPN #3 stated, "I guess to prevent problems." LPN #3 stated that she found her bandage scissors and by using the sharp tipped scissors she could have cut Resident #3's skin under the dressing.

Doctor (Dr.) #5, the Facility's Wound Care Physician, stated during a phone interview on 11/9/17 at approximately 9:49 a.m. that Resident #3's Right Ankle Pressure ulcer was unavoidable as the skin around the area was very different. She stated that Resident #11's Responsible Party, did not want a biopsy performed or any extensive procedures done due to Resident #11's risk factors.

Doctor (Dr.) #4, the Facility's Palliative Care Physician, stated during an interview on 11/9/17 at approximately 11:15 a.m. that Resident #3 had an Atypical wound, complicated by limited mobility after a Brain Stem Stroke. Dr. #4 stated that Resident #3's skin over the Right ankle had no fatty tissue under the skin that would result in a Pressure Ulcer going from a Stage I to an Unstageable extremely quickly. Dr. #4 also stated that Resident #3's diagnosis of Krauosis Vulvae in addition to Resident #3's immobility contributed to her Unavoidable Pressure Ulcer.

Review of the Facility Policy titled, "Handwashing/Hand Hygiene" with a revision date of 8/2015 documented the following:

Wash hands with soap (antimicrobial or non-antimicrobial) and water for the following situations:
After handling used dressings, contaminated equipment, etc.:

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
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 50	F 441		

The use of gloves does not replace hand washing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections.

Review of the Facility Policy titled, "Dressings, Dry/Clean with a revision date of 9/2015 documented the following:

Steps in the Procedure:

Clean bedside stand. Establish a clean field.
Place the clean equipment on the clean field.
Wash and dry your hands thoroughly.
Put on clean gloves. Loosen tape and remove soiled dressing.
Pull glove over dressing and discard into plastic or biohazard bag.
Wash and dry your hands thoroughly
Open dry, clean dressing(s) by pulling corners of the exterior wrapping outward, touching only the exterior surface.
Label tape or dressing with date, time and initials.
Place on clean field.
Using clean technique, open other products prescribed.
Wash and dry your hands thoroughly.
Put on clean gloves.
Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage.
Cleanse the wound with ordered cleanser.
Use dry gauze to pat the wound dry.
Apply the ordered dressing and secure ...per order.
Discard disposable items into the designated container.
Remove disposable gloves and discard into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 51	F 441		

designated container.
Wash and dry your hands thoroughly.
Clean the bedside stand.
Wash and dry your hands thoroughly.

The facility administration was informed of the findings during a briefing on 11/9/17 at approximately 2:02 p.m. The facility did not present any further information about the findings.

DEFINITIONS:

1. Cerebrovascular Accident: (CVA) "Stroke": Medline Plus documented: Strokes happen when blood flow to your brain stops. Within minutes, brain cells begin to die. There are two kinds of stroke. The more common kind, called ischemic stroke, is caused by a blood clot that blocks or plugs a blood vessel in the brain. The other kind, called hemorrhagic stroke, is caused by a blood vessel that breaks and bleeds into the brain. "Mini-strokes" or transient ischemic attacks (TIAs), occur when the blood supply to the brain is briefly interrupted.

2. Non-Alzheimer's Dementia: Denentia that is not Alzheimer's Disease: Medline Plus documented: Dementia is the name for a group of symptoms caused by disorders that affect the brain. It is not a specific disease. People with dementia may not be able to think well enough to do normal activities, such as getting dressed or eating. They may lose their ability to solve problems or control their emotions. Their personalities may change. They may become agitated or see things that are not there.

3. Krauosis Vulvae: National Institute of Health documented: a condition that causes the genitals

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 52	F 441		

to become raw and itchy, and then shrink.

4. Unstageable Pressure Ulcer: National Pressure Ulcer Advisory Panel documented: Unstageable Pressure Injury: Obscured full-thickness skin and tissue loss Full-thickness skin and tissue loss in which the extent of tissue damage within the ulcer cannot be confirmed because it is obscured by slough or eschar. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Stable eschar (i.e. dry, adherent, intact without erythema or fluctuance) on the heel or ischemic limb should not be softened or removed

5. Multi vit with Minerals: Medline Plus documented: multi-vitamin with minerals

6. Prostat: Medline documented: a product that delivers high concentration of protein and calories in a low volume

7. Med Pass: Medline documented: Fortified Nutrition provides a convenient way to supplement calories and protein
· Designed to be used as a medication pass drink

8. Pre-albumin: Medline Plus documented: used as a marker of nutritional status.

9. Hemaglobin: Medline Plus documented: A hemoglobin test measures the levels of hemoglobin in your blood. Hemoglobin is a protein in your red blood cells that carries oxygen from your lungs to the rest of your body. If your hemoglobin levels are abnormal, it may be a sign that you have a blood disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495277	A. BUILDING _____ B. WING _____	C 11/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL NURSING HOME /NA	9468 HOSPITAL ROAD NASSAWADOX, VA 23413

(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 441	Continued From page 53 10. Albumin: Medline Plus documented: An albumin blood test measures the amount of albumin in your blood. Albumin is a protein made by your liver. Albumin helps keep fluid in your bloodstream so it doesn't leak into other tissues. It is also carries various substances throughout your body, including hormones, vitamins, and enzymes. Low albumin levels can indicate a problem with your liver or kidneys.	F 441		