

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

DEC 14 2017

PRINTED: 12/01/2017

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMB NO. 0938-03
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING	·	C 11/09/2017
NAME OF	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	- 1 1110012433
HERITA	GE HALL NURSING H	OME /NA		468 HOSPITAL ROAD IASSAWADOX, VA 23413	•
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIC
F 000	INITIAL COMMEN	rs .	F 000		
	was conducted 11/6 Corrections are req following 42 CFR P Care requirements.	Medicare/Medicaid standard 07/17 through 11/09/17. uired for compliance with the art 483 Federal Long Term The Life Safety Code llow. Five Complaints were			
	139 at the time of the consisted of 29 residents (Resident	145 certified bed facility was ne survey. The survey sample dent reviews: 22 current s #1 through 21 and Residen ecord reviews (Residents #22	ŧ		
	NOTIFY OF CHANG (INJURY/DECLINE) CFR(s): 483.10(g)(14) Notification of	ROOM, ETC) 4) of Changes.	F 157	F-157 Corrective Action(s) Resident #3's resident representative been notified that facility staff failed to notify them timely of a vomiting episothat occurred at breakfast on 11/7/17. Facility Incident & Accident form has	to ode A
	consult with the resi consistent with his c representative(s) wh (A) An accident invo	lving the resident which has the potential for requiring	,	been completed for this incident.  Identification of Deficient Practices & Corrective Action(s): All residents may have potentially beaffected. The DON and Unit Manager will conduct a 100% review of all clir records for the last 30 days to identify	en es es es
	(B) A significant cha mental, or psychoso deterioration in healt status in either life-th clinical complications	nge in the resident's physical cial status (that is, a h, mental, or psychosocial preatening conditions or		residents who may have had changes their medical treatment or condition the would have required physician and responsible party notification. An incident form will be completed for negative findings and will be corrected.	in hat ident r all
	(C) A need to alter the anitimal (C) A need to discontinuted to the alternation (C) A need to alter the al	eatment/significantly (that is, e an existing form of		DEC	1 4 2017

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.

(XE) DAYE

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

PRINTED: 12/01/2017 FORM APPROVED

CENTER	49 FOR MEDICARE	& MEDICAID SERVICES	·		OMB NO. 0938-03	91
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495277	B. WING		C 11/09/2017	
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	1 1110012011	
				9468 HOSPITAL ROAD		
HERITAG	SE HALL NURSING H	OME /NA		NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ILD BE COMPLETIO	)N
F 157	Continued From pa	ine 1	F 1:	57		
	·	dverse consequences, or to	1 1			
		form of treatment); or				
	resident from the fa §483.15(c)(1)(ii).	ansfer or discharge the acility as specified in		Systemic Change(s): The facility policy and procedures been reviewed and no changes are warranted at this time. The 24 Horn Report and documentation in the results.	e ur medical	
		otification under paragraph (g)		record will serve as the source doc	cument	
		n, the facility must ensure that		for communicating changes in resi	ident	
		ation specified in §483.15(c)(2) vided upon request to the		condition/status, refusal of medica	l care	
	physician.	vided apoliticade to the		and treatment and proper notifications responsible parties and physicians.	ion to	
	priy 0.0.0			Licensed staff will be inserviced b	· in the	
		t also promptly notify the sident representative, if any,		DON and/or Regional nurse consu the Notification of Rights & Servic issued a copy of company policy a	ultant on ces and and	
	(A) A change in roomas specified in §483	m or roommate assignment 3.10(e)(6); or		procedure. The inservice will inclust staff education on the timeliness of notification to the attending physic responsible party when changes in	f cian and	
		ident rights under Federal or ions as specified in paragraph on.		treatment or condition occur in ord prevent a delay of services while promoting continuity of care.	er to	
	update the address phone number of the This REQUIREMEN by: Based on observation staff and family interreview, the facility st Representatives of a presidents (Responsible). The facility stample.	t record and periodically (mailing and email) and e resident representative(s). IT is not met as evidenced ions, clinical record review, rview and facility policy taff failed to inform Resident a change in condition for 1 out staff failed to inform Resident esentative of a change in		Monitoring: The DON is responsible for mainta compliance. The DON or Unit Mar will complete weekly chart audits coinciding with the care plan calendary/all negative findings will be corrected at time of discovery. Agg findings of these audits will be reported the QA committee for review, analy and recommendation for changes in facility policy, procedure and/or prescompletion Date: December 24, 2	tregate orted to ysis 12/24/teactice.	17

FORM CMS-2567(02-99) Previous Versions Obsolete

The findings include:

Event ID: NKC611

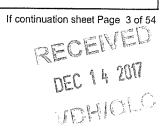
Facility ID: VA0116



PRINTED: 12/01/2017 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB N	O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		495277	B. WING			1	C 1/09/2017
NAME OF	PROVIDER OR SUPPLIER		J	STR	EET ADDRESS, CITY, STATE, ZIP COL		1103/2011
HERITA	GE HALL NURSING H	OME /NA			8 HOSPITAL ROAD SSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	H <b>O</b> ULD BE	(X5) COMPLETION DATE
F 157	Continued From pa	ge 2	Fí	57			
	on 8/1/11 and readr diagnoses that inclu Type II diabetes me	mentia and dysphagia					
	quarterly dated 8/25 with short and long severely impaired in decision making. Redependent on two s living (ADL). The red	nimum Data Set (MDS) was a 1/17 and coded the resident term memory problems and the skills necessary for daily esident #3 was totally taff for all activities of daily sident was assessed with s and on a mechanically					
	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.						
	tour, Resident #3 was coughing with abdor The Certified Nursin resident vomited after chest X-ray had been urse who was moni 11/7/17 at 4:00 p.m., same condition as president's charge nu #6, stated she was to	p.m., during the orientation as observed in bed and ninal muscle movements. g Assistant (#4) stated the er breakfast and a mobile n ordered by the charge toring his condition. On the resident was in the reviously observed. The rese, Licensed Practical Nurse old at shift change the					

X-ray because they as suspicious he may have aspirated after vomiting at breakfast time. She



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES					C	MB NO	0. 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		TE SURVEY MPLETED
		405277	B. WING			1	С
		495277	D. WING			111/	/09/2017
NAME OF	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	SE HALL NURSING H	OME /NA			HOSPITAL ROAD		
				NAS	SAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 157	Continued From pa	ae 3	F 1	57			
		y was not ordered stat, thus it	, ,	01			
		s before the resident received					
		as being monitored for decline					
	in physical status.	3					
		p.m., Resident #3's Resident					
		roached the Charge Nurse,					
		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						
		his morning and we ordering a					
		out aspiration pneumonia?"					
		esentative stated she had not					
		s shocked to see him look the N #6 apologized and stated					
	she should have be						Ì
	Sile dilodia flave be	on danca.					1
	On 11/8/17 at 10:30	a.m., The Director of Nursing					
		her expectation that the staff					
		esident Representative when		-			
		d and the staff ordered the					
		of aspiration. Resident #3 ne local hospital and admitted					
		aspiration pneumonia.					
	With a diagnosis of c	aspiration prisamonia.					
		a.m., an interview was					
		PN (#7) that was in charge of					
		he vomited, 11/7/17. The					
		uring the interview. LPN #7					
		g to call the family member ts were called to the facility.					
		nave been best that she					
		representative when he					
	vomited and they or						İ
	·	-					
	On 11/9/17 at 1:45 p Administrator was in	.m., during the debriefing, the formed of the					

aforementioned issue. The Administrator stated

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
			7 505		С
		495277	B. WING	;	11/09/2017
	PROVIDER OR SUPPLIER  BE HALL NURSING H	OME /NA		STREET ADDRESS. CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE COMPLÉTION
F 157	Resident's Represe vomiting episode ar The facility's policy	ne 7/3 nurse to have called the intative to inform her of the and ordering of the chest X-ray.  and procedure titled Change	F 1	157	
	indicated it was their resident's represent resident's medical/n may not normally reintervention by staff not self limiting" RIGHT TO PARTIC CARE-REVISE CP	IGHT TO PARTICIPATE PLANNING		F-280 Corrective Action(s): Resident #2's comprehensive can have been reviewed and revised falls on 9/4/17 and 9/14/17 and interventions and preventive modure currently in place to prevent fall Incident & Accident Form was for this incident.	to reflect a the casures ls. A
	and implementation plan of care, including land including the right to be included in the planeauth meetings are revisions to the pers.  (ii) The right to partice expected goals and amount, frequency, and other factors related plan of care.  (iv) The right to receincluded in the planeauth for the pl	ipate in the planning process, identify individuals or roles to anning process, the right to ad the right to request on-centered plan of care.  Sipate in establishing the outcomes of care, the type, and duration of care, and any to the effectiveness of the		Resident #14's comprehensive meeting has been conducted wi #14 presence and participation. plan has been reviewed and rev reflect her current interventions treatment needs. A Risk Manag Incident & Accident Form was for this incident.  Identification of Deficient Pra & Corrective Action(s):  Any/all residents may have pote been affected. A 100% review of comprehensive care plans will be conducted by the MDS department identify residents at risk for not invited to care planning and/or their care plans reviewed and retimely. Residents identified at recorrected at time of discovery a Incident & Accident Form will completed for each incident identides.	th resident Her care ised to and ement completed  cetices entially of all be lent to being not having evised isk will be nd a be

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED	
		405077			i	С
		495277	B. WING		11/	09/2017
	PROVIDER OR SUPPLIER  BE HALL NURSING H	OME /NA		STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC (DENTIFYING INFORMATION)	ID PREF TAG		JLD BE	(X5) COMPLETION DATE
F 280	Continued From pa of care.	ge 5	F 2	280		
	right to participate in shall support the resplanning process m  (i) Facilitate the include an assess trengths and needs  (iii) Incorporate the include an assess trengths and needs	usion of the resident and/or tive. ssment of the resident's		Systemic Changes: The nursing assessment process as evidenced by the 24 Hours Report documentation in the medical record/physician orders will be use develop and revise comprehensive of care. The Regional Nurse Consumand/or RCC will provide in-service training to the interdisciplinary care team on the mandate that all reside their resident representatives must invited to attend the care plan meet and that the RCC's are responsible timely review and revisions to the comprehensive care plan must occur	d to plans plant e plan nts and be ing for	
	483.21 (b) Comprehensive	Care Plans		indicated with any changes in cond treatment.		i
		e care plan must be-		<b>Monitoring:</b> The RCC department will be respon	nsible	12/24/17
	(i) Developed within the comprehensive	7 days after completion of assessment.		for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans per care		
	(ii) Prepared by an in includes but is not line	nterdisciplinary team, that mited to		calendar calendar prior to finalizati monitor for compliance. Any/all ne findings will be reported to the DO	on to gative	
	(A) The attending ph			RCC for immediate correction. Det findings of the interdisciplinary tea	ailed m's	
	(B) A registered nurs resident.	se with responsibility for the		audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for		
	resident.	n responsibility for the		change in facility policy, procedure and/or practice.  Completion Date: December 24,	e, -	
	,	d and nutrition services staff.				
	(E) To the extent pra	cticable, the participation of				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NKC611

Facility ID: VA0116

If continuation sheet Page 6 of 54



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

		TO THE STORES				WD 110, 0000 0001		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495277	B. WING	3		C		
NAME OF S	250//DEC OD 01/00//ED	1	L			11/09/2017		
	PROVIDER OR SUPPLIER  BE HALL NURSING HO	OME /NA		STREET ADDRESS, CITY, STATE, ZIP C 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	ODE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD	BE COMPLETION		
	An explanation must medical record if the and their resident renot practicable for the resident's care plan (F) Other appropriated disciplines as deternor as requested by the comprehensive and assessments. This REQUIREMENT by:  Based on resident if facility documentation review the facility stagive a resident the other care plan meeting (Resident #2 and #1). The facility staff from prehensive care occurred on 09/04/1.  The facility staff from prehensive care occurred on 09/04/1.  The facility staff from prehensive care occurred on 109/04/1.  The facility staff from prehensive care occurred on 109/04/1.  The facility staff from prehensive care occurred on 109/04/1.  The facility staff from prehensive care occurred on 109/04/1.  The facility staff from prehensive care occurred on 109/04/1.	e resident's representative(s). It is not met as evidenced interview, staff interviews, on review and clinical record aff failed to update a care plan opportunity to participate in the survey sample.  It is not met as evidenced interview, staff interviews, on review and clinical record aff failed to update a care plan opportunity to participate in the survey sample.  It is not met as evidenced interview, staff interviews, on review and clinical record aff failed to update a care plan opportunity to participate in the survey sample.  It is not met as evidenced interview and clinical record aff failed to update a care plan opportunity to participate in the failed to revise Resident #2's a plan to include a fall that 7 and 09/14/17.  It is not met as evidenced in the survey sample.  It is not met as evidenced in the survey sample in the survey sample.  It is not met as evidenced in the survey sample in the survey sample.  It is not met as evidenced in the survey sample in the survey sample.  It is not met as evidenced in the survey sample in the survey sample in the survey sample.  It is not met as evidenced in the survey sample in the survey sample in the survey sample.  It is not met as evidenced in the survey sample in the survey sample in the survey sample.	F	280				
	behavioral disturban	ces (1).				į		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NKC611

Facility ID: VA0116

If continuation sheet Page 7 of 54



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CLIVILI	TO LOT MEDIONIC	. WINDONID OLIVIOLO			· · · · · · · · · · · · · · · · · · ·	JIND 110. 0000-0001
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING	;		C
		430277	L			11/09/2017
	PROVIDER OR SUPPLIER  E HALL NURSING H	OME /NA		9468	EET ADDRESS, CITY, STATE, ZIP CODE  B HOSPITAL ROAD  SSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
	significant change a Assessment Refere coded the resident memory problems a impairment - never/addition, the MDS of dependence of one toilet use, extensive transfers, dressing a Resident #2's clinical following:  On 09/04/17 at 4:20 the floor; getting out landed on her bottos sitting in an upright  On 09/14/17 at 7:10 the floor with her bareports she slipped active range of motification of the comprehensive 11/08/17, the care phase active and the updating Resident #09/04/17 and 09/14/proceeded to say, the care plan but it's als hours meeting the focare plan is not updating the focare plan is not upd	am Data Set (MDS) a assessment with an ence Date (ARD) of 10/13/17 with short and long term and with severe cognitive frarely made decisions. In coded Resident #2 with total with hygiene, bathing and assistance of one with and bed mobility.  Cal record indicated the assistance of one with and bed mobility.  Cal record indicated the assistance of one with legs out before her, position at the bedside.  Ca.m., resident was sitting on ck against the bed. Resident down. Denies pain with on.  Care plan was reviewed on land did not address Resident 7 and 09/14/17.  Inducted with the MDS 8/17 at approximately 11:45 and 19/14/17.  Inducted with the MDS 8/17 at approximately 11:45 and 19/14/17.  Inducted with the MDS Coordinator are nurses was responsible for 12's care plan after her fall on 17. The MDS Coordinator are nurses should update the odiscussed during our 24 collowing morning and if the lated then I will update it. The	F			
	MDS coordinator sta	ited she didn't have time to				

care plan Resident #2's falls on 09/4/17 or

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OI	<u>MB NO.</u>	<u>0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING		СОМ	E SURVEY PLETED
		495277	B. WING			1	C 09/2017
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE	ZIP CODE	1 11/	JU/EU 11
				9468 HOSPITAL ROAD			
HERITAG	GE HALL NURSING H	OME /NA		NASSAWADOX, VA 23413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD O THE APPROPE	BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 8	F 2	.80			
	finding during a brid approximately 2:00	tration was informed of the efing on 11/09/17 at p.m. The facility did not information about the findings.					
	Definitions:						
	frequently the most	ehavioral disturbances is challenging manifestations of xhibited in almost all people bed/22644311					
	04/02/16. Diagnosi but not limited to Pa Hypothyroidism (2). Minimum Data Set Reference Date (AF	Resident #14 Quarterly (MDS), with an Assessment RD) on 08/16/17 coded BIMS score 15 of a possible					
	11/07/17 at approxing surveyor asked Resinvited to attend her regular basis." Restattended two meeting The resident proceed nurse so I really only	inducted with Resident #14 on mately 3:40 p.m. The lident #14, "Are you being care plan meetings (3) on a lident stated, "I've only logs since I've been here." lided to say, "I'm a retired by don't understand how you in meeting without inviting the					
	an interview with the	oximately 12:05 p.m., during Social Worker (SW), this nat is the process for inviting					

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CLIVIL	NO LOW MEDICANE	A MEDICAID SERVICES				JIVID INC. 0930-039 [
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONS		(X3) DATE SURVEY COMPLETED
						С
		495277	B. WING			11/09/2017
	PROVIDER OR SUPPLIER  GE HALL NURSING H	OME /NA		9468 HO	ADDRESS, CITY, STATE, ZIP CODE SPITAL ROAD WADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
	replied, "I will call the residents personally meeting (3)." The standing called and cathat was scheduled another care plan mescheduled." The #14 was informed of given the opportunit meeting as schedulis new for me; I wall just trying to catch the decision if she want meeting."  An interview was concommented administrator and Decision of the decision of the decision whether attend her own care have been given the attend her own care have been given the The facility administrator inding during a brief approximately 2:00 present any further in The facility's policy: Person-Centered (Reconstruction).	their care plan meeting" she we families and invite the y to attend their care plan SW stated, "Resident #14's unceled the care plan meeting for August 30, 2017 but uneeting was never surveyor asked if Resident of the cancellation and if she my to have her care plan under the SW stated, "No, this ked into a lot after I got her; up but Resident #14 should up opportunity to make her own under the the director of Nursing (DON) on unately 9:15 a.m., the under the swould like to under the should up option.  The resident has the right up on 11/09/17 at up on 11/09/17 at up on 11/09/17 at up on The facility did not unformation about the findings.  Care Plans, Comprehensive	F 2	280		
	includes measurable meet the resident's p	e objectives and timetable to obysical, psychosocial and leveloped and implemented				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NKC611

Facility ID: VA0116

If continuation sheet Page 10 of 54



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				<u>)MR NC</u>	<i>).</i> 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495277	B. WING	-		11	C / <b>09/2017</b>	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
UFDITAC	SELIALI NUDGING U	OBAE /NIA	-	9	468 HOSPITAL ROAD			
HERITAG	SE HALL NURSING H	SIME /NA		V	NASSAWADOX, VA 23413			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 280	Continued From pa	age 10	F2	280				
	for each resident.							
	Policy Interpretation	n and Implementation						
	4. Each resident's person-centered ca							
		s to participate in the						
	development and in plan of care, includi	nplementation of his or her						
	-Participate in the p							
		or roles to be included.						
	<ul><li>-Request meetings</li><li>-Request revisions</li></ul>							
		olishing the expected goals						
	and outcomes of ca	are.						
	-Participate the dete frequency and dura	ermining the type, amount, ition of care.						
	5. The resident will to participate in his	be informed of his or her right or her treatment.						
		as the right to refuse to evelopment 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).							
	decreased activity of	is a condition characterized by of the thyroid gland (Mosby's ne, Nursing & Health						

Professions, 7th Edition).

CLIVIL	TO LOU MEDIONIL	O MEDIONID DEITMOLD				1012110	. 0000 000 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		NSTRUCTION		TE SURVEY MPLETED
			/				С
		495277	B. WING	·		11/	/09/2017
	PROVIDER OR SUPPLIER	OLET ALA	·	1	T ADDRESS, CITY, STATE, ZIP CODE IOSPITAL ROAD		
HERITAC	SE HALL NURSING H	OME /NA		NASS	AWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 280	Continued From pa	ge 11	F:	280			
	will get your health health condition to pyou're able), your fa someone acting on take part in planning home staff (HTTPS://www/wha-plan-in-nursing-home provide CARE/S WELL BEING CFR(s): 483.24, 48 483.24 Quality of life is a fu applies to all care a residents. Each residents. Each residents. Each residents are sidents or practicable physical well-being, consiste comprehensive ass 483.25 Quality of care is a fapplies to all treatm facility residents. Bassessment of a residents receivaccordance with propractice, the comprehensive ass that residents receivaccordance with propractice, the comprehensive to the comprehensive ass that residents receivaccordance with propractice, the comprehensive asset that the comprehensive asset that residents receivaccordance with propractice, the comprehensive asset that the comprehensive asset that residents receivaccordance with propractice, the comprehensive asset that the comprehensi	endamental principle that and services provided to facility sident must receive and the the necessary care and maintain the highest, mental, and psychosocial and with the resident's essment and plan of care.  The fundamental principle that ent and care provided to used on the comprehensive sident, the facility must ensure the treatment and care in offessional standards of enensive person-centered esidents' choices, including a following:	Fí	309	F309 Corrective Action(s): Residents #22's attending physicia notified that the facility failed to e MS contin was available for administration and the facility staft to administer Zofran as ordered by physician. A facility Incident and Accident form was completed for incident.  Identification of Deficient Practices/Corrective Action(s): All other residents receiving medimay have been potentially affecte DON, QA nurse and Unit Manage conduct a 100% audit of all reside MAR's to identify resident at risk Residents identified at risk will be corrected at time of discovery and attending physicians will be notified each negative finding and a facilit Incident & Accident Form will be completed for each negative finding	risure  If failed the this  cations d. The ers will ents  it is it their ided of cy	
	The facility must en	sure that pain management is swho require such services,					

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB N	<u>0. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		LE CONSTRUCTION		ATE SURVEY OMPLETED
		495277	B. WING		a and a substitution of the substitution of th	1	C <b>1/09/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIEDITAC	SE HALL MUDGING U	OBATE /N.A.	ĺ	94	468 HOSPITAL ROAD		
HERHAU	SE HALL NURSING H	JIME /NA		N	IASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 309	Continued From parconsistent with profithe comprehensive and the residents' go (I) Dialysis. The fact residents who requiservices, consistent of practice, the comprehensive and the residents who requiservices, consistent of practice, the comprehensive and the resident services. This REQUIREMENT by:  Based on observatinterviews, facility derecord review, the facility staff fails orders for the admir Contin for (Resident Contin for (Resident Resident #22 was one of the Staff fails of the current Minimula admission assessming Reference Date (AFresident with a 15 of the Brief Interview for the comprehensive for	ge 12 essional standards of practice, person-centered care plan, loals and preferences.  cility must ensure that re dialysis receive such with professional standards prehensive person-centered esidents' goals and  IT is not met as evidenced ion, resident interview staff ocumentation and clinical acility staff failed to follow 1 out 29 Residents in the sident #22).  ed to follow the physician histration of Zofran and MS transport #22.  riginally admitted to the facility included but not limited to		<u></u>	CROSS-REFERENCED TO THE APPROP	ave the in the nains ment are, ician urse tions  QA lit for gs and ll be s of erly ity	
	dependence of one bathing and toilet us one with bed mobilit	ident #22 requiring total with dressing, hygiene, e, extensive assistance of y and limited assistance of activities of Daily Living care.					

Resident #22's comprehensive care plan

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	49 LOK MEDICAKE	& MEDICAID SERVICES			, , , , , , , , , , , , , , , , , , ,	DIA GINIC	<del>J. 0930-039 i</del>	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE		ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495277	B. WING			11	C I/ <b>09/2017</b>	
NAME OF I	PROVIDER OR SUPPLIER	J		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
UCDITAC	STILALI MUDGING LI	ORAE (NIA		9468	HOSPITAL ROAD			
HERITAC	SE HALL NURSING H	OWE /NA		NAS	SAWADOX, VA 23413			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE	
F 309	cancer - Resident five weakness, tiredness depression from cathan 3 on a 1-10 part Some of the interversional included: Meditineffective.  Review of the current but not limited to the October 2016:  1. MS Contin 60 m mouth every 12 hou 2. Xeloda 500 mg to daily x 14 days for 0 10/3/16.  3. Zofran 8 mg table minutes before each days not receiving 2 During the review of the current fill the continuation of the current fill the cu	nt with a stage IV breast £22 is at risk for excessive s, weight loss, pain and nocer process. The goal: less in scale by next review. Ention/approaches to manage cation as ordered - report if at physician orders included to following medications for g tablet - give 1 tablet by urs of pain.  ablet - give 4 tablets twice cancer (chemo) - stop date et - give 1 tablet by mouth 30 th dose of Xeloda - hold on	F	309	DEFICIENCY)			
	and the medication	a missed doses MS Contin Zofran was administered ds to hold when Xeloda is not			·			
	October 2016, Medi (MAR) revealed the not administered on	the review of Resident #22's cation Administration Record medication MS Contin was 10/14/16 at 9:00 a.m., ilable - hard script obtained).						
		nducted with DON on nate 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

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	19 LOV MEDICALE	. A MEDICAID SERVICES			OMD NO. 0930-039 I
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		405077	D WING		С
		495277	B. WING		11/09/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			1	9468 HOSPITAL ROAD	
HERITAC	SE HALL NURSING H	OME /NA		NASSAWADOX, VA 23413	
				TRAGATIADON, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLÉTION
F 309	Continued From pa	ae 14	F 3	ina	
. 000			1 3	09	
		e pharmacy and requested for			
		ome over stat (immediately)			
	which takes about 2	2-3 hours for delivery.			
		the review of Resident #22's			
	MAR for October 21	106 indicated that resident			
	refused Xeloda on t	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 med	lication Zofran 8 mg even			
		ads to hold when not receiving			
	Xeloda.	3			
		onducted with the Director of 1/8/17 at approximately 6:00			
	p.m., who stated the administered on the	e Zofran should not have been days Resident #22 refused DN proceeded to say she			
		es to follow physician orders			
		inducted with LPN #4 on			
	surveyor asked, "W	mately 12:10 p.m., the hat is the process for			
		ed pain medications" the LPN			
		vill check the back of the card,			
		ick of the narcotic card it will			
	indicate whether or	not a hard script is needed or			
		still available for reordering."			
		the medication is scheduled;			
		re there is enough pills so we			
		e should every go without their			
		ecially if they are terminally ill.			
		I, the pharmacy can be called			
	and they will stat ove	er the medication but it a hard			
	script is needed, the	doctor will have to come in a			
		refill which can cause a delay			
	in receiving the med				

The facility's Administration was informed of the



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMR MC	<del>). 0938-039</del> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495277	B. WING		11	C /09/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE	
LIEDITA	ST HALL MUDGING U	ORAE /NIA		9468 HOSPITAL ROAD		
HERITAG	SE HALL NURSING H	OWE /NA		NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 309	Continued From pa	age 15	F3	309		
		riefing 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 Decembe					
		Medications shall be				
		afe and timely manner, and as				
	prescribed.					
	Policy Interpretation	and Implementation				
	3. Medications mus	t be administered in				
		e orders, including and				
	required time frame	e. Iministering the medication				
		el THREE (3) times to verify				
	the right resident, ri	ght medication, right dosage,				
	right time and right					
	administration before	re giving the medication.				
	Definitions:					
		plasm characterized by the				
		of anaplastic cells that tend				
		ng tissue and to metastasize s (Mosby's Dictionary of				
		R Health Professions, 7th				
	Edition).					
	2 Anemia is condit	ion when blood does not carry				
		ne rest of your body (Source:				
	NIH U.S. National L	ibrary of Medicine				
	<a href="https://www.nlm.ni">https://www.nlm.ni</a>					
	_ga=1.222831837.7 Medline Plus).	792012784.1475525034>:				
	3. Xeloda is used in	n combination with other				
		breast cancer that has come				
	back after has no	t improved after treatment				

with other medications

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
						1	С
		495277	B. WING			11/0	09/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRES	SS, CITY, STATE, ZIP CODE		
1 IEDITA	OF HALL MUDONICH	OBATT /NA		9468 HOSPITAL	. ROAD		
HERITAG	GE HALL NURSING H	UME /NA		NASSAWADO	X, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH	VIDER'S PLAN OF CORRECTIC CORRECTIVE ACTION SHOULI REFERENCED TO THE APPROP DEFICIENCY)	O BE	(X5) COMPLETION DATE
F 309			F 3	09			
	(nttps://mediineplus	.gov/ency/article/007365.htm).					
	severe pain	ed to relieve moderate togov/ency/article/007365.htm).					
F 314	5. Zofran is used to caused by cancer of therapy, and surger (https://medlineplus	o prevent nausea and vomiting hemotherapy, radiation ygov/ency/article/007365.htm). deficiency.	F 3	14 LPN :	ective Action(s): #3 involved in Resident #8 nent observation has been in		:
SS=D	CFR(s): 483.25(b)(1			proce	oper clean dressing change dures, hand washing and in ol practices when performing ing change for proper infect	ng a	
	(1) Pressure ulcers. comprehensive ass facility must ensure	cers. Based on the assessment of a resident, the		contr prom durin treatr	control and prevention measures to promote healing and prevent infect during pressure ulcer wound care treatment procedures. A facility In & Accident form was completed f		
	(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			incident and Call of the All of t		etice(s) care tial nd/or Unit pass ssing ction culcer gative ediately indicated.	

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>INB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		E SURVEY PLETED
							3
		495277	B. WING		······································	11/0	09/2017
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
		ONE DIA		9468	HOSPITAL ROAD		
HERITAG	SE HALL NURSING H	OME /NA		NAS	SAWADOX, VA 23413		
(X4) IĎ PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	Continued From pa		F	314			
	potential complicati (Resident #8 and R sample size of 29. 1. The facility staff facomplications were for Resident #8. 2. The facility staff facomplications	rd procedures to prevent the ons for two Residents tesident #11) in the survey ailed to ensure potential avoided during wound care failed to ensure potential avoided during wound care			Systemic Change(s):  The facility Policy and Procedure Wound Care has been reviewed a changes are warranted at this tim licensed nursing staff will be insubjected by the Wound care physician and DON on the facility's Pressure L Treatment and Prevention Policy Procedure. Training will include of the infection control policy an procedures for providing proper control measures during pressure wound care treatments.	and no ne. The erviced d/or the JIcer v and a review d infection	
	11/11/16. Diagnose but are not limited to (1), Non-Alzheimer' Vulvae* (3).  Resident #11's Quatassessment protocome Reference Date of with short and long moderate memory in During an observation approximately 9:45 care for an Unavoid Facility Acquired on Resident #11 was ly bilateral heel presson Practical Nurse (LP washing her hands.)	as admitted to the facility on es for Resident #11 included o Cerebrovascular Accident* s Dementia* (2), and Krauosis arterly Minimum Data Set (an ol) with an Assessment 7/18/17 coded Resident #11 term memory problems with mpairment.			Monitoring: The DON is responsible for com The wound care physician will re residents identified with pressure wounds weekly. The wound car physician will assess and evaluat document the progression of wor healing weekly. The DON or QA designee will complete two rand treatment pass audits weekly to e proper infection control technique dressing procedures are being ap wound care treatments. Any/all if findings will be addressed at time discovery. The results of the audition sent to the Quality Assurance Co monthly for review, analysis, and recommendations for change in policy, procedure, and/or practice Completion Date: December 2	eview all e ulcer te and und A nurse or lom ensure ues and oplied to negative ae of dits will be facility ce.	12/24/17

FORM CMS-2567(02-99) Previous Versions Obsolete

had dried, LPN #3 doffed her gloves and washed

non-permeable barrier on the table and placed

her hands. LPN #3, then placed a

Event ID: NKC611

Facility ID: VA0116

If continuation sheet Page 18 of 54



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTERO FOR MEDICANE	A MEDICAID SERVICES			CIVIL	3 140. 0000 000 i
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	į .	TIPLE CONSTRUCTION DING	(X	(3) DATE SURVEY COMPLETED
					С
	495277	B. WING			11/09/2017
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NURSING H	OME /NA		STREET ADDRESS, CITY, STATE. ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	ODE	
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	
used sanitized poin soiled dressing from After the soiled dred dred did not remove her #3 using soiled glow Resident #3's Right Dermal Wound Clethe Pressure Ulcer, Ointment to the word dressing with calcius covered with a sterial gauze fluff wrapheremoved her gloves Resident #3's Clinical following:  11/3/17 Physician Cover with dry gauze change QD (daily) and dislodges.  1/21/17 Physician Cover with dry gauze change QD (daily) and dislodges.	und care on the table. LPN #3 ted tip scissors to cut off the n Resident #11's Right ankle. ssing was removed, LPN #3 gloves and wash hands. LPN ves, proceeded to cleanse theel Pressure Ulcer with anser (DWC). After cleansing LPN #3 applied Santyl und bed, and covered the im alginate dressing and then le dressing and secured with The LPN secured the trash, is and washed her hands.  cal Record documented the  Order: Cleanse Right ankle Wound Cleanser (DWC), pat over with calcium alginate, e, wrap with rolled gauze, and PRN (as needed) if soiled  Order: Multivit-minerals* (5) sule daily supplement  Order: Prostat* (6) 30 dwice a day  Order: Med Pass* (7) 90 every night  Order: Heel Float Boots at all	F	314		
7/15/17 Physician C	order: Fortified foods on all				

meal trays

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

	TO TOTT WILD TO THE	CAMEDIO/NO CENTICE				711D 110. 0000-000 1
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CO	(X3) DATE SURVEY COMPLETED	
		405077				С
		495277	B. WING			11/09/2017
	PROVIDER OR SUPPLIER  BE HALL NURSING H	OME /NA		9468	ET ADDRESS, CITY, STATE, ZIP CODE HOSPITAL ROAD SAWADOX, VA 23413	
				117101		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 314	Continued From pa	ge 19	F:	314		
	12/12/16 Physician meal	Order: Yogurt with every				
	11/14/16 Physician meals	Order: patient to be fed all				
	Resident #11's Care problem:	e Plan with the following				
	#11) will have no sk	or skin breakdown: (Resident in breakdown through next tinence and immobility.				
	Interventions include following:	ed but were not limited to the				
	Treatment orders per Weekly skin assess Provide diet as orde					
		ake to physician es if resident refuses to eat e resident nutritional status as				
	ordered	Boots while in bed. Remove				
	The 6/23/16 CNA Ca following:	are Plan documented the				
	Toileting: Assisted Bathing: Assisted Eating/Feeding: Indi					

Ambulation: Wheel chair

CENTE	48 FUR MEDICARE	& MEDICAID SEKVICES			(	JMR MC	). <del>0938-0391</del>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	CO	TE SURVEY MPLETED
		495277	B. WING			1	C / <b>09/2017</b>
	PROVIDER OR SUPPLIER  BE HALL NURSING H	OME /NA		946	REET ADDRESS, CITY, STATE, ZIP CODE 58 HOSPITAL ROAD ASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE	(X5) COMPLETION DATE
	whenever out of bed Dietary Note of 11/2 following:  "been eating 26-Pureed with honey continued to monitod Dietary notes: 1/10 4/11/17, 4/21/17, 5/7/24/17 3:37 p.m. Notes and Care Nurse LPN #3 seen by Dr. (# 5) for Area was cleansed surgically excised or devitalized tissue arto a depth of 0.3 cm tissue at this time. Shound bed covered covered with dry gas secured with dry gas secured with tape at 7/24/17 Note of Dr. following:  Date wound identified Location: Right ank Stage: Unstageable Drainage: Serous, Stage: Unstage	Device: Boot Left Ankle/ Wear d  22/16 documented the  100% of meals. Diet is thickened liquids. Dietary or Resident #11 as indicated by 1/17, 1/22/17, 2/17/17, 3/28/17, 19/17, and 6/27/17.  Itursing Note of the Wound of documented: "Resident was rew area to Right ankle. with DWC pat dry and f 5.62 centimeters (cm) of and necrotic subcutaneous fat revealing healthy belled Santyl ointment was applied to with calcium alginate then uze wrapped with rolled gauze to the time"  (#5) documented the  ed: 7/24/17  le edue to slough/eschar Small  or 90%  ontake: 50%  ce: 50%	F3	314			
	Average Dinner intal	ke: /5%					

PRINTED: 12/01/2017 FORM APPROVED

CENTE	RS FOR MEDICARE	: & MEDICAID SERVICES			(	<u> DMR MC</u>	) <u>. 0938-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		TE SURVEY MPLETED
		495277	B. WING			11	C / <b>09/2017</b>
NAME OF	PROVIDER OR SUPPLIER	<u> </u>		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	SE HALL NURSING H	OME /NA			B HOSPITAL ROAD		
				NAS	SSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa Current Weight 181 Admission Weight:	.20 pounds	F 3	14			
	Lab Work:						
	mg/dL (milligrams p 7/6/17 Hemaglobin' gm/dL (grams per o 10/26/17 Albumin* ( gm//dL: 3.4 to 4.8) 10/26/17 Hemaglob gm/dL 12 to 16) LPN #3 was asked	* (8) 16.8 Low (normal Range per deci Liter) 18.38) * (9) 11.3 Low (normal Range leci Liter) 12 to 16) (10) 2.8 Low (normal Range len 11.4 Low (normal Range len 11.4 Low (normal Range len 11/8/17 at approximately lend bandage scissors. LPN #3					
	stated, "Somewhere LPN #3 was asked 4:00 p.m. if she sho						
	#3 stated that she d been nervous during surveyor asked if sh soiled gloves and we cleansing the Press probably should hav #3 stated, "I guess t stated that she foun- by using the sharp ti	idn't know and that she had g the observation. After the le should have removed her ashed her hands after ure Ulcer, she stated, "I re." When asked why, LPN o prevent problems." LPN #3 d her bandage scissors and pped scissors she could have in under the dressing.					
	Physician, stated du 11/9/17 at approxima #3's Right Ankle Pre as the skin around the	Facility's Wound Care ring a phone interview on ately 9:49 a.m. that Resident ssure ulcer was unavoidable ne area was very different. dent #11's Responsible					

Party, did not want a biopsy performed or any



CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			Y	OMB NO	D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY
		495277	B. WING			11	C / <b>09/2017</b>
NAME OF I	PROVIDER OR SUPPLIER	I	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		10312011
					168 HOSPITAL ROAD		
HERITAC	GE HALL NURSING H	OME /NA			ASSAWADOX, VA 23413		
()(1)(5)	CIMMAD V CTA	TEMENT OF DEFICIENCIES				<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 22	F3	₹14	,		
	=	es done due to Resident #11's	, .	, , -,			
	Physician, stated dat approximately 11 an Atypical wound, after a Brain Stem 3 Resident #3's skin of fatty tissue under the Pressure Ulcer goir Unstageable extremstated that Resident Vulvae in addition to contributed to her Unstageable extremstated that Resident Vulvae in addition to contributed to her Unstageable extremstated that Resident Vulvae in addition to contributed to her Unstageable extremediate of the Facilia Dry/Clean with a revidence of the Procedulate	ure:  d. Establish a clean field. ipment on the clean field. hands thoroughly Loosen tape and remove sing and discard into plastic					
	Place on clean field. Using clean techniques prescribed. Wash and dry your help Put on clean gloves.	ue, open other products					

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	45 FUR MEDICARE	& MEDICAID SERVICES				NAIR IAC	J. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		ATE SURVEY MPLETED
		495277	B. WING			11	C I/ <b>09/2017</b>
NAME OF F	PROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
LEDITAC	E UALL MUDEINO U	ONE INA	-	946	68 HOSPITAL ROAD		
HERHAU	SE HALL NURSING H	OME AVA		NA	ASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa	ige 23	F 3	14			
	•	and surrounding skin for					
		rainage, tissue healing					
	progress and wound						
		with ordered cleanser.					
	Use dry gauze to pa	at the wound dry. Iressing and secureper					
	order.	ressing and secureper					
		items into the designated					
		gloves and discard into					
	designated contained	er.			•		
	Wash and dry your	<b>U</b> ,					
	Clean the bedside s						
	Wash and dry your	nands thoroughly.					
	The facility administ	tration was informed of the					
	findings during a bri						
	approximately						
	2:02 p.m. The facili information about the	ty did not present any further					
	information about th	e indings.					
	DEFINITIONS:						
	1. Cerebrovascular	Accident: (CVA) "Stroke":					
		nented: Strokes happen when					
		rain stops. Within minutes,					
		die. There are two kinds of					
		ommon kind, called ischemic					
		a blood clot that blocks or I in the brain. The other kind,					
		stroke, is caused by a blood					
	vessel that breaks a	nd bleeds into the brain.					
		nsient ischemic attacks					
	• "	the blood supply to the brain					
	is briefly interrupted.						
	2. Non-Alzheimer's	Dementia: Denentia that is					

not Alzheimer's Disease: Medline Plus

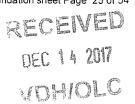
documented: Dementia is the name for a group

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391		
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	ULTIPLE CONSTRUCTION LDING		(X3) DATE SURVEY COMPLETED	
		495277	B. WING	;		į	C <b>09/2017</b>
NAME OF	PROVIDER OR SUPPLIER		-	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
HERITA	GE HALL NURSING H	OME /NA			8 HOSPITAL ROAD SSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	brain. It is not a specific dementia may not be do normal activities eating. They may lo problems or control personalities may cagitated or see thing.  3. Krauosis Vulvae documented: a conto become raw and.  4. Unstageable Prepressure Ulcer Advi Unstageable Pressure full-thickness skin as skin and tissue loss damage within the ubecause it is obscur slough or eschar is 4 pressure injury wil (i.e. dry, adherent, in fluctuance) on the hot be softened or resolution.  5. Multi vit with Mindocumented: multi-vit with Mindocumented: mul	ed by disorders that affect the exific disease. People with the eable to think well enough to a such as getting dressed or use their ability to solve their emotions. Their hange. They may become ges that are not there.  : National Institute of Health adition that causes the genitals itchy, and then shrink.  essure Ulcer: National isory Panel documented: ure Injury: Obscured and tissue loss Full-thickness in which the extent of tissue ulcer cannot be confirmed and the solution of Stage and the solution of the solution of the eschar and the extent of the ext	F:	314			

drink

Designed to be used as a medication pass



CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB N	O. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONST		(X3) D	ATE SURVEY OMPLETED
		495277	B. WING			1	C 1/09/2017
	PROVIDER OR SUPPLIER GE HALL NURSING H	OME /NA		9468 HOS	DDRESS, CITY, STATE, ZIP CODE	<del>~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~</del>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	× (	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO ROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	as a marker of nutr  9. Hemaglobin: Methemoglobin test methemoglobin in your protein in your red to from your lungs to themoglobin levels at that you have a blood  10. Albumin: Medlalbumin blood test ralbumin in your blood by your liver. Album bloodstream so it do It is also carries var your body, including	edline Plus documented: used itional status.  edline Plus documented: A easures the levels of blood. Hemoglobin is a blood cells that carries oxygen he rest of your body. If your are abnormal, it may be a sign od disorder.  ine Plus documented: An measures the amount of bod. Albumin is a protein made in helps keep fluid in your besn't leak into other tissues. It is substances throughout in hormones, vitamins, and min levels can indicate a	F3	14			
	to the facility on 07/2 #8 included but are (1), and a stage IV (ulcer (3). Resident with an Assessment 10/27/17 coded the possible score of 15 Mental Status (BIMS cognitive impairment coded Resident #8 retwo with toilet use, trand bathing, extension mobility and extension eating. Resident #8	admitted originally admitted 27/15. Diagnosis for Resident not limited to Type 2 Diabetes 2) sacral wound pressure #8 Minimum Data Set (MDS) Reference Date (ARD) of resident with a 09 of a total on the Brief Interview for 6), indicating moderate t. In addition, the MDS equiring total dependence of ansfers, dressing, hygiene we assistance of two with bed re assistance of one with was coded always has indwelling Foley (3).					

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

	& MEDICAID SERVICES			OMR M	OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	495277	B. WING	Philip for the control of the contro	1	C <b>1/09/2017</b>		
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NURSING HO	OME /NA		STREET ADDRESS, CITY, STATE, Z 9468 HOSPITAL ROAD NASSAWADOX, VA 23413				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 314 Continued From page	ge 26	F3	314				
coded Resident #8 a ulcers, having a stag was coded as having ulcer with the following 4.5 cm x 1 cm depth tissue-pink or red tis granular appearance.  Resident #8 revised documented Reside breakdown to sacrum secondary to left and amputation. The good develop any new are residents pressure un healing as evidenced improved appearance symptoms (s/s) of in the current treatmer cleanse sacrum with pat dry, apply Santyl to wound, apply calcular and cover with padding and as needed.  On 11/08/17 at approximations appearance wound, apply calcular and cover with padding and as needed.	comprehensive care plan ent #8 with actual skin m related to impaired mobility d right below knees als: the resident will not eas of skin breakdown and alcer will exhibit signs of d by decreased in size, be and be free from signs and fection.  Int as of 10/31/17 is to a Puracyn (wound cleanser), (4) then calcium alginate (5) ium alginate to periwound ed adhesive dressing daily						

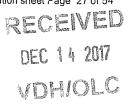
FORM CMS-2567(02-99) Previous Versions Obsolete

cleaner), area patted dry, Santyl applied to outer

Event ID: NKC611

Facility ID: VA0116

If continuation sheet Page 27 of 54



CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				MB NC	0. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY MPLETED
		495277	B. WING	;		11	C / <b>09/2017</b>
NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
HEDITA	GE HALL NURSING H	OME ALA		94	468 HOSPITAL ROAD		
HERHA	SE HALL NORSING H	ONE MA		N	ASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 27	F 3	314			
	edges of wound be	d (slough area) using tongue Algicell dressing (6) then					ĺ
	interview was condustrial should have remove the soiled dressing, on another pair of gremove my gloves to the soiled dressing (DON) on 1 p.m., who stated, "Twashed her hands a wound care was stated dressing her removed, hands was cleanse the wound, her hands, put on not the soiled dressing the soiled dressing her removed, hands was cleanse the wound, her hands, put on not the soiled dressing the soiled dressing her removed, hands was cleanse the wound, her hands, put on not the soiled dressing the soi	roximately 10:35 a.m., and ucted with LPN who stated, "I ed my gloves after I removed washed my hands then put loves, cleaned the wound, hen wash my hands again."  Inducted with the Director of 1/08/17 at approximately 5:40 the nurse should have and put on gloves before arted, after the removal of the gloves should have been shed new gloves applied, removed her gloves, washed ew gloves then after wound loves removed and hands					
	finding during a brie approximately 2:00	ration was informed of the fing on 11/09/17 at o.m. The facility did not nformation about the findings.					
	The facility's policy for (Revised 09/2015).	or Dressings, Dry/Clean				•	
	provide guidelines fo	se of this procedure is to or the application of dry, clean the Procedure to include but					
	2. Place the clean ed	d. Establish a clean field. uipment on the clean field. so they can be easily					

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	<u> </u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION DING	(X3) DA	ATE SURVEY OMPLETED
		495277	B. WING		1	C 1/ <b>09/201</b> 7
	PROVIDER OR SUPPLIER  GE HALL NURSING H	OME /NA		STREET ADDRESS, CITY, STATE, ZIP CO 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
	reached. 3. Tape a biohazard stand or use a wast 4. Position resident access to affected a 5. Wash and dry ha 6. Put on clean glow soiled dressing. 7. Pull glove over dry plastic or biohazard 8. Wash and dry you 9. Open dry, clean of the exterior wraph the exterior surface Definitions:  1). Diabetes Mellitudisease in which the (glucose) in the block (https://medlineplus. 2). Pressure Injury and tissue loss) Full-thickness skin a or directly palpable filgament, cartilage of and/or eschar may be edges), undermining Depth varies by analeschar obscures the an Unstageable Presentation.	d or plastic bag on the bedside the basket below clean field. and adjust clothing to provide area. Indistributes, loose tape and remove tressing and discard into bag. It hands thoroughly. It discard thoroughly. It is a lifelong corners pring outward, touching only in the state of sugar or the state of the sugar of t	F 3	114		
		A pressure injury is localized and underlying soft tissue				

usually over a bony prominence or related to a

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENIE	KO FOR MEDICAKE	& MEDICAID SERVICES			OMR M	<i>J.</i> 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		TE SURVEY
		495277	B. WING	Notes that the same of the sam	11	C 1 <b>/09/2017</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	
HERITA	GE HALL NURSING H	OME /NA	l	9468 HOSPITAL ROAD		
				NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR  X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	medical or other de as intact skin or an painful. The injury of and/or prolonged procombination with shissue for pressure affected by microcli co-morbidities and of (http://www.npuap.o-clinical-resources/re	ge 29 vice. The injury can present open ulcer and may be occurs as a result of intense ressure or pressure in the art. The tolerance of soft and shear may also be mate, nutrition, perfusion, condition of the soft tissue org/resources/educational-and apuap-pressure-injury-stages/)  The help the healing of burns hase is an enzyme. It works up and remove dead skin and tray also help to work better pody's natural healing processcom/cold-and-flu/rm-quiz-anti	F3	14		
	alginate, a gelatinous ubstance. When in calcium alginate in the sodium chloride from dressing into a hydromoist environment of (www.medicaldepartsings-s/286.htm).  6). Algicell dressing heavily exudating would have been desired the company of th	manages moderately to bunds ehealth.com/algicell-ag-alginaml).				

environment, preventing eschar formation and

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	!						С
	co original	495277	B. WING			11	1/09/2017
NAME OF H	PROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAC	GE HALL NURSING H	OME /NA		1	9468 HOSPITAL ROAD		
			1	'	NASSAWADOX, VA 23413		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	age 30	F 3	314	4		Particular Control of the Control of
	promoting rapid, tro	=		•	•		
	(http://www.hightide	ehealth.com/allevyn-adhesive-f					
	oam-dressings-hom	ne.html).					
	FREE OF ACCIDEN		F 3	323	3		
SS=D	HAZARDS/SUPER				F323		
	CFR(s): 483.25(d)(1	T)(2)(n)(T)-(3)			Corrective Action(s):		
	(d) Accidents.				LPN #3 involved in Resident #11's		
	The facility must en	sure that -			treatment observation has been in- serviced on proper clean dressing cha	2200	
					procedures to include using Bandage		
		vironment remains as free			Scissors for removing all dressings a	and	
	from accident hazar	rds as is possible; and			bandages from residents when perfor	rming	
	(2) Each resident re	eceives adequate supervision			a dressing change to prevent potentia	al	
		ices to prevent accidents.			injury during wound and skin care procedures. A facility Incident &		intrulia
	una ussississis	000 to provent add.22			Accident form was completed for thi	is	13-10-7111
		e facility must attempt to use			incident.		
		ives prior to installing a side or					
		side rail is used, the facility			Identification of Deficient Practice	(s)	
		t installation, use, and I rails, including but not limited			and Corrective Action(s): All other residents with wound care		
	to the following elem				treatments may have been potential		
	10 110 10.10 1	Torne.			affected. The DON, QA nurse and/or		
		lent for risk of entrapment			Manager will conduct treatment pass	3	
	from bed rails prior to	o installation.			audits to monitor for proper dressing	,	
	(O) Deviley, the state	The second secon			change techniques and that bandage scissors are used when removing		
		and benefits of bed rails with ent representative and obtain			dressings and bandages during pressu	ıre	
	informed consent pri				ulcer wound and skin care treatments	s.	
	miorinos consone <sub>p</sub>	ion to motemation.			Any negative findings will be address		
	(3) Ensure that the b	ped's dimensions are			immediately and disciplinary action t as indicated. A facility Incident and	aken	
		esident's size and weight.			Accident form will be completed for	each	
		IT is not met as evidenced			negative finding.	Cacii	
	by:	on, resident interview, staff					
		on, resident interview, stan					
		cility staff failed to ensure					
		prevent a potential accident of					

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		(	<u> DMB NO. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 11/09/2017
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/00/2011
				9468 HOSPITAL ROAD	
HERITA	SE HALL NURSING H	OME /NA		NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION
F 323	Continued From pa	ige 31 s skin, were utilized when	F 3	23 Systemic Change(s):	
	cutting off a soiled of scissors and not ba	dressing using pointed tipped andage scissors for 1 t #11) in the survey sample		The facility Policy and Procedure 1 Wound Care has been reviewed an modified to include bandage scisso the required equipment to be used dressing and bandage removal. Th	nd ors as during
	The findings include	ed:		licensed nursing staff will be in-se by the DON on the facility's Press	rviced
	11/11/16. Diagnose but are not limited to	admitted to the facility on es for Resident #11 included o Cerebrovascular Accident* s Dementia* (2), and Krauosis		Ulcer and Wound Treatment and Prevention Policy and Procedure. Training will include a review of t procedures and equipment used dupressure ulcer wound care and dre changes.	ıring
	assessment protoco Reference Date of I with short and long moderate memory i During an observati approximately 9:45 care for an Unavoid Facility Acquired on Resident #11 was ly bilateral heel pressu Practical Nurse (LP washing her hands. Resident #11's over had dried, LPN #3 d her hands. LPN #3, non-permeable barr her supplies for wou used sanitized point soiled dressing from After the soiled dres did not remove her g #3 using soiled glove	on on 11/8/17 at a.m., of Resident #11's wound able Atypical Unstageable 7/24/17, Pressure Ulcer* (4). ring on an air mattress with ure relief boots on. Licensed N) #3 began wound care by LPN #3 then sanitized -bed table. After the table loffed her gloves and washed		Monitoring: The DON is responsible for comp The DON or QA nurse or designe complete two random treatment pr audits weekly to ensure proper inf control techniques and dressing procedures are being applied to we care treatments and dressing chang Any/all negative findings will be addressed at time of discovery. The results of the audits will be sent to Quality Assurance Committee mo for review, analysis, and recommendations for change in fa policy, procedure, and/or practice Completion Date: December 24	e will ass fection ound ges.  The property of the partial of the p

CLIVIL	NO FOR MEDICARE	A MEDICAID SERVICES				TIND INC	<i>J.</i> 0930-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION		TE SURVEY MPLETED
		495277	B. WING			11	/09/2017
	PROVIDER OR SUPPLIER  BE HALL NURSING H	OME /NA		9468	ET ADDRESS, CITY, STATE, ZIP CODE HOSPITAL ROAD SAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	the Pressure Ulcer, Ointment to the word dressing with calciu covered with a steri a gauze fluff wrap.	anser (DWC). After cleansing LPN #3 applied Santyl und bed, and covered the malginate dressing and then the LPN secured the trash, is and washed her hands.	F3	i23			
	Resident #3's Clinical Record documented the following:						
	wound with Dermal dry, apply santyl, co cover with dry gauze	Order: Cleanse Right ankle Wound Cleanser (DWC), pat ver with calcium alginate, e, wrap with rolled gauze, and PRN (as needed) if soiled					
		order: Multivit-minerals* (5) sule daily supplement					
	4/21/17 Physician C milliliters by mouth t	order: Prostat* (6) 30 wice a day					
	5/20/17 Physician Order: Med Pass* (7) 90 milliliters by mouth every night						
	6/14/17 Physician O times, Remove durin	rder: Heel Float Boots at all ng ADL care					We will be a second of the sec
	7/15/17 Physician O meal trays	rder: Fortified foods on all					
	12/12/16 Physician ( meal	Order: Yogurt with every					
	11/14/16 Physician (	Order: patient to be fed all					

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

<u> </u>	TO LOW MEDICARE	A MEDIONID SERVICES	<del></del>		Oiv	ID NO. 0930-039 I	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495277	B. WING			C <b>11/09/2017</b>	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE	reconstruction of the second o	
				9468 HOSPITAL ROAD			
HERITAC	BE HALL NURSING H	OME /NA		NASSAWADOX, VA 234	413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B ED TO THE APPROPRI, ICIENCY)		
F 323	Continued From pa Resident #11's Care problem:	ge 33 e Plan with the following	F3	323			
	#11) will have no sk	or skin breakdown: Resident in breakdown through next tinence and immobility.					
	Interventions included but were not limited to the following:						
	Treatment orders per Weekly skin assess Provide diet as order each meal. Report decline in into Offer food substitute Dietician to evaluate ordered	ments ered. Record food intake % at ake to physician es if resident refuses to eat e resident nutritional status as Boots while in bed. Remove					
	following: "been eating 26-' Pureed with honey the continued to monitor	2/16 documented the 100% of meals. Diet is hickened liquids. Dietary Resident #11 as indicated by 17, 1/22/17, 2/17/17, 3/28/17, 9/17, and 6/27/17.					
	Care Nurse LPN #3: Dr. (# 5) for new are cleansed with DWC excised of 5.62 centitissue and necrotic s	ursing Note of the Wound "Resident was seen by a to Right ankle. Area was pat dry and surgically imeters (cm) of devitalized ubcutaneous fat to a depth healthy belled tissue at this					

time. Santyl ointment was applied to bound bed

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

	TO TOTA WILDION TAL	C WILDIOM OCH WIOLO			3111D 110. 0330-0331
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 11/09/2017
NAME OF F	PROVIDER OR SUPPLIER	**************************************	<b></b>	STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAG	E HALL NURSING H	OME /NA	•	9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	and the second s	D BE COMPLETION
F 323	dry gauze wrapped tape at the time"	ge 34 m alginate then covered with with rolled gauze secured with (#5) documented the	F	323	
	following:  Date wound identification: Right ank	ed: 7/24/17 kle e due to slough/eschar Small  or 90%  ontake: 50% ke: 75%  .20 pounds			
	mg/dL 18.38) 7/6/17 Hemaglobin* gm/dL 12 to 16) 10/26/17 Albumin* (' gm//dL: 3.4 to 4.8) 10/26/17 Hemaglobi gm/dL 12 to 16)  LPN #3 was asked o	(8) 16.8 Low (normal Range (9) 11.3 Low (normal Range 10) 2.8 Low (normal Range n 11.4 Low (normal Range on 11/8/17 at approximately d bandage scissors. LPN #3			

LPN #3 stated that she found her bandage

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	: & MEDICAID SERVICES			<u>UI</u>	VIB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		495277	B. WING	i		C <b>11/09/2017</b>
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
HERITA	GE HALL NURSING H	OME /NA		9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD HE APPROPE	BE COMPLETION
F 323	Continued From pa	ge 35	F 3	323		
		ng the sharp tipped scissors Resident #3's skin under the				
	at approximately 4: should be used to do Director of Nursing scissors are the coursed to not potential Doctor (Dr.) #5, the Physician, stated du 11/9/17 at approxim #3's Right Ankle Preas the skin around to She stated that Res Party, did not want at	sing #2 was asked on 11/8/17 10 p.m. what type of scissors but off a soiled dressing. The #2 stated that bandage rect type of scissors to be ally cut the patient's skin.  Facility's Wound Care uring a phone interview on lately 9:49 a.m. that Resident essure ulcer was unavoidable the area was very different. Sident #11's Responsible a biopsy performed or any es done due to Resident #11's				
	Physician, stated duat approximately 11 an Atypical wound, of after a Brain Stem Stem Stem Stem Stem Stem Stem Stem	Facility's Palliative Care uring an interview on 11/9/17 :15 a.m. that Resident #3 had complicated by limited mobility Stroke. Dr. #4 stated that over the Right ankle had no e skin that would result in a g from a Stage I to an ely quickly. Dr. #4 also : #3's diagnosis of Krauosis of Resident #3's immobility navoidable Pressure Ulcer. sing was asked if the Facility ed to the type of scissors to are on 11/8/17 at o.m. The Director of Nursing				

stated that there was no specific policy or

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			(	<u>OMB NC</u>	<u>). 0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		ATE SURVEY OMPLETED
							С
		495277	B. WING			11	1/09/2017
NAME OF F	PROVIDER OR SUPPLIER		T	[ ]	STREET ADDRESS, CITY, STATE, ZIP CODE		
		OBSE /NA	l	!	9468 HOSPITAL ROAD		
HERITAG	E HALL NURSING H	JME /NA	-		NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 36	F 3	323	3		
	•	ound care policy related to the					
	type of scissors. The	he Director of Nursing stated,					
	that her expectation	for her nursing staff was to					
	utilize bandage scis cause any accident	ssors so as not to potentially potentials.					
	The facility administ	tration was informed of the					
	findings during a bri	iefing on 11/9/17 at					
	approximately 2:02	p.m. The facility did not					
	present any further	information about the findings.					
	DEFINITIONS:						
	Medline Plus documblood flow to your bbrain cells begin to stroke. The more costroke, is caused by plugs a blood vesse called hemorrhagic vessel that breaks a "Mini-strokes" or tra	r Accident: (CVA) "Stroke": nented: Strokes happen when train stops. Within minutes, die. There are two kinds of the brain kind, called ischemic y a blood clot that blocks or el in the brain. The other kind, stroke, is caused by a blood and bleeds into the brain. Insient ischemic attacks the blood supply to the brain.					
	not Alzheimer's Disa documented: Demo of symptoms cause brain. It is not a spe	Dementia: Denentia that is ease: Medline Plus entia is the name for a group d by disorders that affect the ecific disease. People with					

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



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				<u>)MB NC</u>	0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495277	B. WING			11	C / <b>09/2017</b>
NAME OF I	PROVIDER OR SUPPLIER		<u>' Т</u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
			į	94	468 HOSPITAL ROAD		
HERITAG	BE HALL NURSING H	OME /NA		N.	IASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICENCY)	D BE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 37	F 3	23			
	•	dition that causes the genitals	, 0.				
		itchy, and then shrink.					
	Pressure Ulcer Advi Unstageable Pressur full-thickness skin at skin and tissue loss damage within the ubecause it is obscur slough or eschar is 4 pressure injury will (i.e. dry, adherent, in fluctuance) on the h not be softened or re- 5. Multi vit with Mind documented: multi-vi-						
	Nutrition provides a supplement calories						
	8. Pre-albumin: Me as a marker of nutrit	dline Plus documented: used ional status.					
	hemoglobin test mea hemoglobin in your b protein in your red bl from your lungs to th	dline Plus documented: A asures the levels of blood. Hemoglobin is a cod cells that carries oxygen e rest of your body. If your e abnormal, it may be a sign					

that you have a blood disorder.

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

OLIVILI	TO I OIT WILLDION ITE	A MILDIOMID OLIVATOLO	<del></del>			<del>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</del>	
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUC			E SURVEY MPLETED
							С
		495277	B. WING			11/	0.9/2017
	PROVIDER OR SUPPLIER GE HALL NURSING H	OME /NA		9468 HOSPIT	RESS, CITY, STATE, ZIP CODE FAL ROAD DOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	PF IX (EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD S-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa	age 38	F:	323			
F 441 SS=D	albumin blood test albumin in your blood by your liver. Album bloodstream so it delt is also carries varyour body, including enzymes. Low album problem with your life INFECTION CONTUNENS CFR(s): 483.80(a)(c) (a) Infection prevent The facility must est and control program a minimum, the following the following services the communicable dise volunteers, visitors, providing services that conducted according accepted national simplementation is Program, who limited to:  (i) A system of survey possible communication in the program, who limited to:	ROL, PREVENT SPREAD,  1)(2)(4)(e)(f)  Ition and control program.  Itablish an infection prevention in (IPCP) that must include, at owing elements:  Eventing, identifying, reporting, ontrolling infections and leases for all residents, staff, and other individuals under a contractual in upon the facility assessmenting to §483.70(e) and following tandards (facility assessment	F	LPN Obsi beer hand prace proce Acc incid  Ider Cor All have imp cont Mar aud infe han adm find and faci	rective Action(s):  N #3 involved in the Treatment servation for Resident's #8 & # inserviced one-on-one on productices to be followed during treatedures. A Facility Incident & sident form was completed for tident.  ntification of Deficient Praction rective Action(s): residents receiving wound care the potential to be affected by proper hand washing and infection to techniques. The DON and/mager will conduct a treatment lit on LPN #3 to observe proper dection control practices and product washing during the treatment inistration procedure. Any negdings will be addressed immedial disciplinary action taken as negative for completed for each negative fire	11 has oper al atment this this sece(s) & emay you ion for Unit pass reper t gative iately eeded. An will	12/24/17

FORM CMS-2567(02-99) Previous Versions Obsolete

facility;

Event ID: NKC611

Facility ID: VA0116

If continuation sheet Page 39 of 54



PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	E & INIEDICAID SERVICES		,	JIVID INU.	0930-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED	
		495277	B. WING	)	1	C 09/2017
NAME OF F	PROVIDER OR SUPPLIER	A		STREET ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	E HALL NURSING H	OME /NA		9468 HOSPITAL ROAD NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
F 441	communicable disereported;  (iii) Standard and tr to be followed to pr  (iv) When and how resident; including It  (A) The type and dodepending upon the involved, and  (B) A requirement the least restrictive posticumstances.  (v) The circumstance must prohibit employed contact with resider contact will transmit (vi) The hand hygie by staff involved in contact will transmit (vi) The hand hygie by staff invo	ansmission-based precautions event spread of infections; isolation should be used for a put not limited to:  uration of the isolation, infectious agent or organism that the isolation should be the sible for the resident under the sible for the resident under the exes under which the facility byces with a communicable skin lesions from direct the ortheir food, if direct the disease; and the procedures to be followed direct resident contact.  Fording incidents identified PCP and the corrective of facility.  The facility will conduct an	F 4	Systemic Change(s): The facility policy and procedul been reviewed and no changes a warranted at this time. All licen will be inserviced on the facility and procedure for proper hand and the infection control policy procedure by the DON and/or Fourse Consultant.  Monitoring: The DON is responsible for ma compliance. The DON, Unit M and/or designee will perform 2 weekly Treatment Pass audits to nursing staff for compliance. Four the audits will be reported to the Committee for review, analysis recommendations for change in policy, procedure, and/or practice. Completion Date: December 1.	are sed staff policy washing and degional intaining anager random o monitor ndings of e QA , and a facility ce.	12/24/17
	annual review of its	IPCP and update their				

program, as necessary.

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

						1		
STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED	
							С	
		495277	B. WING	B. WING			11/09/2017	
NAME OF PROVIDER OR SUPPLIER				Γ	STREET ADDRESS, CITY, STATE, ZIP CODE			
DEDITAGE HALL MID	NAE INIA			9468 HOSPITAL ROAD				
HERITAGE HALL NURS	SING HC	JIVIE /NA			NASSAWADOX, VA 23413			
PREFIX (EACH DE	FICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE	
by: Based on ol	REMEN bservati	ge 40 IT is not met as evidenced on, clinical record review, revised of the facility	F 4	44	1			

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

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

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

The findings included:

sample.

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,

If continuation sheet Page 41 of 54

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
	495277 B. WING			
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL NURSING HOME /NA			STREET ADDRESS, CITY, STATE, ZIP CODE 9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION

#### F 441 Continued From page 41 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.

F 441

Facility ID: VA0116

PRINTED: 12/01/2017 FORM APPROVED

CENTER	OC EOD MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	\		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING			C 11/09/2017
	PROVIDER OR SUPPLIER  BE HALL NURSING H			STRI 9468	EET ADDRESS, CITY, STATE, ZIP CODE B HOSPITAL ROAD SSAWADOX, VA 23413	11//00/20
(X4) ID PREFIX TAG	SUMMARY STA	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICIENCY)	D BE COMPLETION
F 441	On 11/09/17 at app interview was cond "I should have removed the soiled then put on another wound, remove my again."  An interview was conditionally a conditionally and the recommendation of the province of	roximately 10:35 a.m., and ucted with LPN #3 who stated, by over my gloves after I dressing, washed my hands pair of gloves, cleaned the gloves then wash my hands onducted with the Director of 11/09/17 at approximately 5:05. The nurse should have before wound care was moval of soiled dressing, after I and again after the dressing eted."  tration was informed of the efing on 11/09/17 at p.m. The facility did not information about the findings. for Hand/Hand Hygiene  lity considers hand hygiene the prevent the spread of mand Implementation included hall be trained and regularly mportance of hand hygiene in smission of ted infections.	F	141		

Facility ID: VA0116

prevent the spread of infections to other

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	42 FOR MEDICARE	& MEDICAID SERVICES				T	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	,		ONSTRUCTION		E SURVEY IPLETED
		40.5077	B. WING				C 00/2047
		495277	B. WING		TO CORP. OF THE CORP.	1 17	09/2017
NAME OF F	PROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE  HOSPITAL ROAD		
HERITAG	E HALL NURSING H	OME /NA			SAWADOX, VA 23413		
						N.I	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	COMPLETION DATE
F 441	Continued From pa	ae 43	F 4	l41			
	personnel, resident						
	least 62% alcohol; (antimicrobial or no the following situati-Before handling clapads, etcBefore moving from a clean body site displayed and the contact with landling use equipment, etc.  9. The use of glove washing/hand hygicalong with routine his the best practice for healthcare-associal	ean or soiled dressings, gauze m a contaminated body site to uring resident care. blood or bodily fluids. d dressings, contaminated es does not replace hand ene. Integration of gloves use hand hygiene is recognized as r preventing					
	disease in which th (glucose) in the blo	us Type II is a lifelong (chronic) ere is a high level of sugar od s.gov/ency/article/007365.htm).					
	and tissue loss) Full-thickness skin or directly palpable ligament, cartilage and/or eschar may edges), underminin Depth varies by and eschar obscures th an Unstageable Pro (http://www.npuap.org)	and tissue loss with exposed fascia, muscle, tendon, or bone in the ulcer. Slough be visible. Epibole (rolled g and/or tunneling often occur. atomical location. If slough or e extent of tissue loss this is essure Injury. org/resources/educational-and npuap-pressure-injury-stages/)					

PRINTED: 12/01/2017 FORM APPROVED

CENTER	S EOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING	-		C 11/09/2017
NAME OF I	PROVIDER OR SUPPLIER		L	STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
		ONGT /NIA		9468	HOSPITAL ROAD	
HERITAG	SE HALL NURSING H	OME /NA		NAS	SSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 441	Continued From pa	ge 44	F	141		
	and underlying soft prominence or related device. The injury copen ulcer and may as a result of intension pressure in combitolerance of soft tismay also be affected perfusion, co-morbitissue (http://www.npuap.u-clinical-resources/	localized damage to the skin tissue usually over a bony ted to a medical or other can present as intact skin or any be painful. The injury occurs se and/or prolonged pressure bination with shear. The sue for pressure and shear ed by microclimate, nutrition, idities and condition of the soft org/resources/educational-and npuap-pressure-injury-stages/) to help the healing of burns anase is an enzyme. It works up and remove dead skin and may also help to work better body's natural healing process d.com/cold-and-flu/rm-quiz-antices and water-insoluble in contact with a wound, the the dressing reacts with the mound. This turns the rophilic gel that maintains a				

heavily exudating wounds

6). Algicell dressing manages moderately to

PRINTED: 12/01/2017 FORM APPROVED

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			(	<u>)MB NC</u>	<u>). 0938-0391</u>
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		INSTRUCTION		TE SURVEY MPLETED
		495277	B. WING			11	C /09/2017
NAME OF F	DOWNER OF SUPPLIER		- T	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				HOSPITAL ROAD		•
HERITAG	E HALL NURSING H	OME /NA			SAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Continued From pa (https://www.hightic te-dressing-home.h 7). Allevyn Dressin maintenance of a menvironment, preve promoting rapid, tro (http://www.hightide oam-dressings-home 2. Resident #11 wa 11/11/16. Diagnose but are not limited to (1), Non-Alzheimer Vulvae* (3).  Resident #11's Qua assessment protoc Reference Date of with short and long moderate memory  During an observat approximately 9:45 care for an Unavoic Facility Acquired on Resident #11 was bilateral heel pressing Practical Nurse (LF washing her hands Resident #11's over	ge 45 Idehealth.com/algicell-ag-algina atml).  g allows for the formation and noist wound healing nting eschar formation and buble-free healing chealth.com/allevyn-adhesive-fne.html).  as admitted to the facility on es for Resident #11 included to Cerebrovascular Accident* is Dementia* (2), and Krauosis arterly Minimum Data Set (an ol) with an Assessment 7/18/17 coded Resident #11 term memory problems with impairment.  ion on 11/8/17 at a.m., of Resident #11's wound dable Atypical Unstageable 17/24/17, Pressure Ulcer* (4). In ying on an air mattress with ure relief boots on. Licensed PN) #3 began wound care by LPN #3 then sanitized rebed table. After the table doffed her gloves and washed	F 4	41	DEFICIENCY)		
	her supplies for woused sanitized poin	rier on the table and placed und care on the table. LPN #3 ted tip scissors to cut off the n Resident #11's Right ankle.					

Facility ID: VA0116

After the soiled dressing was removed, LPN #3 did not remove her gloves and wash hands. LPN

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES				MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495277	B. WING			C 11/09/2017
		+30277	L		REET ADDRESS, CITY, STATE, ZIP CODE	11/00/2011
NAME OF F	ROVIDER OR SUPPLIER				8 HOSPITAL ROAD	
HERITAG	E HALL NURSING H	OME /NA				
TIERTIAG	L IMEL NORONO			NA	SSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION (EACH CONTRACT)	D BE COMPLETION
F 441	Resident #3's Right Dermal Wound Cle the Pressure Ulcer, Ointment to the wo dressing with calciu covered with a ster a gauze fluff wrap. removed her gloves Resident #3's Clinic following: 11/3/17 Physician C wound with Dermal dry, apply santyl, co cover with dry gauz change QD (daily) or dislodges.  1/21/17 Physician C tablet take one cap 4/21/17 Physician C milliliters by mouth 5/20/17 Physician C by mouth every nig 6/14/17 Physician C times, Remove dur 7/15/17 Physician C meal trays 12/12/16 Physician meal 11/14/16 Physician meals  Resident #11's Car problem:	ves, proceeded to cleanse t Heel Pressure Ulcer with leanser (DWC). After cleansing I LPN #3 applied Santyl und bed, and covered the um alginate dressing and then ille dressing and secured with The LPN secured the trash, is and washed her hands.  Cal Record documented the Drder: Cleanse Right ankle Wound Cleanser (DWC), pat over with calcium alginate, ie, wrap with roiled gauze, and PRN (as needed) if soiled  Order: Multivit-minerals* (5) sule daily supplement Order: Prostat* (6)* (7) 30 twice a day Order: Med Pass 90 milliliters ht Order: Heel Float Boots at all ing ADL care Order: Fortified foods on all  Order: Yogurt with every  Order: patient to be fed all e Plan with the following	F 4	141		
	11/22/16 Potential f	for skin breakdown: (Resident				

FORM CMS-2567(02-99) Previous Versions Obsolete

#11) will have no skin breakdown through next

Event ID: NKC611

Facility ID: VA0116

If continuation sheet Page 47 of 54



PRINTED: 12/01/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO. 093	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SUF COMPLET	
		495277	B. WING			C 11/09/2	017
NAME OF F	PROVIDER OR SUPPLIER	<u></u>	<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				9,	468 HOSPITAL ROAD		
HERITAG	SE HALL NURSING H	OME /NA		N	IASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	DBE COV	(X5) MPLETION DATE
F 441		age 47 ntinence and immobility. Hed but were not limited to the	F	141			
	Treatment orders p Weekly skin assess Provide diet as ordeach meal. Report decline in in Offer food substitut Dietician to evaluat ordered	sments ered. Record food intake % at htake to physician htes if resident refuses to eat he resident nutritional status as ht Boots while in bed. Remove					
	following: "been eating 26 Pureed with honey continued to monito Dietary notes: 1/10	22/16 documented the i-100% of meals. Diet is thickened liquids. Dietary or Resident #11 as indicated by 0/17, 1/22/17, 2/17/17, 3/28/17, /19/17, and 6/27/17.					
	Care Nurse LPN # was seen by Dr. (# Area was cleansed devitalized tissue at to a depth of 0.3 cr tissue at this time.	Nursing Note of the Wound 3 documented: "Resident 5) for new area to Right ankle. I with DWC pat dry and of 5.62 centimeters (cm) of and necrotic subcutaneous fat m revealing healthy belled Santyl ointment was applied to d with calcium alginate then auze wrapped with rolled gauze at the time"					

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OND ITO. GGG CGG T
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND MEDER.		LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495277	B. WING	<b>.</b>	C 11/09/2017
NAME OF E	POVIDER OR SLIPPLIER	495277	15. 11.10	STREET ADDRESS, CITY, STATE, ZIF	
NAME OF PROVIDER OR SUPPLIER				9468 HOSPITAL ROAD	
HERITAG	E HALL NURSING H	OME /NA		NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 441	Continued From pa	age 48	F	441	
	Drainage: Serous, Measurements: Length: 2.5 cm Width: 2.5 cm Depth: 0.00 cm Wound Bed: Esch Nutritional Review: Average Breakfast Average Lunch Inta Average Dinner int Current Weight 18 Admission Weight: Lab Work: 4/20/17 Prealbuming/dL 18.38)	kle le due to slough/eschar Small  ar 90%  Intake: 50% ake: 50% ake: 75% 1,20 pounds 219 pounds n* (8) 16.8 Low (normal Range	•		
	gm/dL 12 to 16) 10/26/17 Albumin* am//dL: 3.4 to 4.8	* (9) 11.3 Low (normal Range (10) 2.8 Low (normal Range ) bin 11.4 Low (normal Range			
	LPN #3 was asked 10:00 a.m., if she h stated, "Somewher	l on 11/8/17 at approximately nad bandage scissors. LPN #3 re."	3		
	4:00 p.m. if she sh again during woun #3 stated that she been nervous during	on 11/8/17 at approximately ould have washed her hands d care of Resident #11. LPN didn't know and that she had ng the observation. After the she should have removed her			

Facility ID: VA0116

soiled gloves and washed her hands after

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			JIVIB INO. 0930-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED
		495277	B. WING _		11/09/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
70			İ	9468 HOSPITAL ROAD	
HERITAGE HALL NURSING HOME /NA			NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETION
F 441	Continued From pa	ige 49	F 44	11	

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.:

Facility ID: VA0116

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		<u>U</u>	VID INO. 0930-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		405077	B. WING		C 44/00/2047
		495277	B. WING		11/09/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIEDITAC	E HALL NURSING H	OME /NA		9468 HOSPITAL ROAD	
HERITAG	E HALL NORSING I	OME /NA		NASSAWADOX, VA 23413	
(X4) ID PREFIX TAG	(FACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		BE COMPLETION
F 441	washing/hand hygicalong with routine he the best practice for healthcare-associal Review of the Facil Dry/Clean with a redocumented the following for the Process of the Pr	does not replace hand ene. Integration of glove use hand hygiene is recognized as it preventing ted infections.  ity Policy titled, "Dressings, vision date of 9/2015 llowing:  dure:  id. Establish a clean field.  uipment on the clean field.  hands thoroughly.  is. Loosen tape and remove essing and discard into plastic  hands thoroughly essing(s) by pulling corners of any outward, touching only the sing with date, time and initials.  d.  que, open other products  hands thoroughly.  s.  and surrounding skin for rainage, tissue healing and stage.  d with ordered cleanser.  at the wound dry.  dressing and secureper	F 4	41	
		items into the designated			

Remove disposable gloves and discard into

container.

PRINTED: 12/01/2017 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			ATE SURVEY OMPLETED
		495277	B. WING		1	C <b>1/09/2017</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
				9468 HOSPITAL ROAD		
HERITAC	SE HALL NURSING H	OME /NA		NASSAWADOX, VA 23413		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		IOULD BE	(X5) COMPLETION DATE
F 441	Continued From padesignated contained Wash and dry your Clean the bedside wash and dry your	er. hands thoroughly. stand.	F 4	i41		
	findings during a br approximately 2:02	tration was informed of the iefing on 11/9/17 at p.m. The facility did not information about the findings.				
	Medline Plus docur blood flow to your b brain cells begin to stroke. The more constroke, is caused by plugs a blood vesse called hemorrhagic vessel that breaks a "Mini-strokes" or tra	r Accident: (CVA) "Stroke": nented: Strokes happen when rain stops. Within minutes, die. There are two kinds of ommon kind, called ischemic y a blood clot that blocks or el in the brain. The other kind, stroke, is caused by a blood and bleeds into the brain. Insient ischemic attacks the blood supply to the brain.				•
	not Alzheimer's Dis documented: Dem of symptoms cause brain. It is not a spe dementia may not be do normal activities eating. They may lo problems or control personalities may of	Dementia: Denentia that is ease: Medline Plus entia is the name for a group of by disorders that affect the ecific disease. People with the eable to think well enough to such as getting dressed or use their ability to solve their emotions. Their hange. They may become gs that are not there.				

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

Facility ID: VA0116

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	E & MEDICAID SERVICES			OMR N	<u>U. 0938-0397</u>	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495277	B. WING		. 1	C 1/09/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT			
		ONE INIA	1	9468 HOSPITAL ROAD			
HERITAG	GE HALL NURSING H	OME /NA		NASSAWADOX, VA 2341	3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
F 441	Continued From pa	nge 52	F 4	41			
	•	l itchy, and then shrink.	• •				
	Pressure Ulcer Adv Unstageable Press full-thickness skin a skin and tissue loss damage within the obecause it is obscu slough or eschar is 4 pressure injury wi (i.e. dry, adherent, i fluctuance) on the h not be softened or r 5. Multi vit with Min documented: multi- 6. Prostat: Medline delivers high concein in a low volume	nerals: Medline Plus vitamin with minerals documented: a product that intration of protein and calories					
	Nutrition provides a supplement calories						
	8. Pre-albumin: Me as a marker of nutri	edline Plus documented: used tional status.					
	hemoglobin test me hemoglobin in your protein in your red b from your lungs to the	edline Plus documented: A easures the levels of blood. Hemoglobin is a blood cells that carries oxygen he rest of your body. If your are abnormal, it may be a sign					

that you have a blood disorder.

PRINTED: 12/01/2017 FORM APPROVED OMB NO. 0938-0391

OLIVILI	TO T OIT WEDIONITE	. WINICHID SERVICES			MD NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495277	B. WING		C 11/09/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
HERITAGE HALL NURSING HOME /NA				9468 HOSPITAL ROAD NASSAWADOX, VA 23413	
/V4\1D	SUMMARY STA	TEMENT OF DEFICIENCIES			\1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLÉTION
F 441	albumin blood test r albumin in your blood by your liver. Album bloodstream so it do It is also carries vari your body, including	ine Plus documented: An measures the amount of od. Albumin is a protein made in helps keep fluid in your pesn't leak into other tissues, ious substances throughout in hormones, vitamins, and min levels can indicate a	F 44	DEFICIENCY)	
					1