STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495152	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	121 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 05/22/18 through 05/24/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 05/22/18 through 05/24/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 180 certified bed facility was 136 at the time of the survey. The survey sample consisted of 28 current Resident reviews and 3 closed record reviews.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578	**F578** **Corrective Action(s):** Residents #106 has had their DDNR form reviewed by the DON and the attending physician and it has been updated and correctly completed to reflect resident #106's code status. An Incident and Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Admission Director and/or Social Services Director will review all resident's medical records to ensure the DDNR is accurately filled out. Any negative findings with result in the Admission Director and/or Social Services Director to contact all responsible parties to verify each resident's code status and advance	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon D. Hiatt RN, LNHA

TITLE: Administrator

(X6) DATE: 6-18-18

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

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F 578	Continued From page 1 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure the Durable Do Not Resuscitate Order (DDNR) was complete for 1 of 31 residents (Resident #106). The facility staff failed to ensure the Virginia Department of Health Durable Do Not Resuscitate Order (DDNR) was complete and accurate for Resident #106. The findings included: The clinical record of Resident #106 was reviewed 5/22/18 through 5/24/18. Resident	F 578	directives to insure that the proper status has been explained and that written notification has been placed in the medical record. **Systemic Change(s);** The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director has been inserviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator & Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record. **Monitoring:** The Admission Director and Social Services Director are responsible for maintaining compliance. The Admission Director and/or Social Service Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date: 07/06/18**	

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F 578	Continued From page 2	F 578		

#106 was admitted to the facility 4/24/18 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, cognitive communication deficit, hyperlipidemia, anxiety, heart failure, osteoarthritis, metabolic encephalopathy, chronic kidney disease, major depressive disorder, history of falls, left artificial hip joint, Type 2 diabetes mellitus, urinary tract infection, unspecified psychosis, peripheral vascular disease, pressure ulcer left heel, unstageable, pressure ulcer right heel, unstageable, and pressure ulcer, coccyx, stage 2.

Resident #106's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/1/18 assessed the resident with a BIMS (brief interview for mental status) as 3 out of 15.

Resident #106's clinical record had a Virginia Department of Health DDNR form dated 4/30/18 and signed by the nurse practitioner and the power of attorney.

Under section 1, the DDNR read in part, "I further certify [must check 1 or 2]:
1. The patient is CAPABLE of making an informed decision...
2. The patient is INCAPABLE of making an informed decision..."

The boxes beside #1 and #2 had been left blank.

Section 2 read "If you checked 2 above, check A, B, or C below:" The three boxes below had also been left blank.

The surveyor informed the director of nursing of

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F 578	Continued From page 3 the above concern on 5/23/18 at 4:33 p.m. The DON stated the DDNR was usually completed upon admission to the facility. The DON acknowledged the DDNR form was not completed for Sections 1 and 2. The surveyor informed the administrator and the director of nursing of the concern with Resident #106's DDNR on 5/23/18 at 5:13 p.m. No further information was provided prior to the exit conference on 5/24/18.	F 578		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility.	F 755	**F755** **Corrective Action(s):** The unused medication identified during a medication cart review for unit 2 has been removed and properly disposed of. A facility Incident and Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All medication carts and medication rooms may have potentially been affected. A 100% review of all medication carts and medication rooms has been conducted by the DON, ADON and/ or Unit managers to identify any unused medication not properly removed and disposed of. Any unused medication identified in medication carts or medication rooms will be removed and properly disposed of. A facility Incident and Accident form has been completed for each.	

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F 755	Continued From page 4 §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to dispose of unused medications on one of four units (unit 2). The facility staff failed to dispose of a Residents gentamicin after the Resident had finished the course of antibiotic therapy. The findings included. On 05/22/18 at approximately 12:30 p.m. while checking the medication cart with LPN (licensed practical nurse) #1, the surveyor observed a bottle of gentamicin eye drops that belonged to a Resident of the facility (Resident #89). These eye drops were dated 03/29/18 and were to be administered over a 7-day period. After reviewing, the EHR (electronic health record) LPN #1 verbalized to the surveyor that the order for the eye drops had ended on 04/04/18 and she would discard them. On 05/22/18 at approximately 2:15 p.m., the administrator was notified that the medication cart on unit 2 contained medication (antibiotic) that had ended almost 7 weeks ago.	F 755	**Systemic Changes:** The Pharmacy Policy and Procedure has been reviewed and no changes are warranted. All licensed nursing staff have been inserviced on the Policy and Procedure for removal and destruction of unused or discontinued resident medications from all medication carts and medication rooms. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON or Unit manager will conduct weekly audits of all medication carts and medication rooms to monitor for compliance. All negative findings will be corrected at the time of discovery. Results of the reviews will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:07/06/18**	

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F 755	Continued From page 5 The facility provided the surveyor with a copy of their policy/procedure titled "Discontinued Medications" on 05/22/18 this policy/procedure read in part "Staff shall destroy discontinued medications or shall return them to the dispensing pharmacy in accordance with facility policy..." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 755		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-	F 842	**F842** **Corrective Action(s):** Resident #106's attending physician has been notified that the facility staff failed to accurately document resident #106's weekly skin inspection as not intact. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all current resident weekly skin inspections will be conducted by the DON, ADON, and/or Unit Managers to identify residents at risk. All negative findings will be correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff will be inserviced by the DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate	

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F 842	Continued From page 6 (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F 842	medical records and clinical documentation to include weekly resident skin inspections according to the acceptable professional standards and practices. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the care plan schedule to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 07/06/18**	

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F 842	Continued From page 7	F 842		

services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure the 5/15/18 skin inspection sheet was accurate for 1 of 31 residents (Resident #106).

The facility staff failed to ensure the 5/15/18 skin inspection sheet was accurate for Resident #106.

The findings included:

The clinical record of Resident #106 was reviewed 5/22/18 through 5/24/18. Resident #106 was admitted to the facility 4/24/18 with diagnoses that included but not limited to unspecified dementia with behavioral disturbances, cognitive communication deficit, hyperlipidemia, anxiety, heart failure, osteoarthritis, metabolic encephalopathy, chronic kidney disease, major depressive disorder, history of falls, left artificial hip joint, Type 2 diabetes mellitus, urinary tract infection, unspecified psychosis, peripheral vascular disease, pressure ulcer left heel, unstageable, pressure ulcer right heel, unstageable, and pressure ulcer, coccyx, stage 2.

Resident #106's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/1/18 assessed the resident with a BIMS (brief interview for mental status) as 3 out of 15. Section M Skin Conditions assessed the resident to be at risk for developing pressure ulcers and was assessed with two (2) unstageable -deep tissue injury ulcers.

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The current comprehensive care plan dated 5/2/18 identified Resident #106 to have a problem with skin due to decreased mobility. Resident #106 has SDTI (deep tissue injury) on right and left heels. Approaches were to monitor skin frequently.

The surveyor reviewed the weekly skin inspection report for May 2018. The skin inspection report dated 5/15/18 read "Skin Intact."

The wound assessment report dated 5/18/18 identified a stage 2 pressure area on Resident #106's coccyx that was first identified on 5/11/18. The wound assessment report stated the wound had small serous drainage and measured 1.00 cm (centimeters) x 0.20 cm x 0.10 cm.

The documentation on the 5/15/18 skin inspection was inaccurate. Resident #106's skin was not intact. The nurse that assessed Resident #106 was no longer employed at the facility and an interview could not be done.

The surveyor informed the administrator and the director of nursing of the concern with Resident #106's skin assessment documentation on 5/24/18 at 3:40 p.m. and requested the facility policy on documentation.

The facility policy titled "Charting and Documentation" was reviewed 5/24/18. The policy read in part "3. Documentation in the medical record will be objective (not opinionated or speculative), complete and accurate."

No further information was provided prior to the exit conference on 5/24/18.

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F 880 SS=D	Continued From page 9 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections;	F 880	**F880** **Corrective Action(s):** The attending physician for Resident #62 was notified that C.N.A. #1 failed to appropriately apply the Isolation Personal Protective Equipment (PPE) prior to delivering care in the resident's room. C.N.A. #1 has been inserviced by the DON on the proper contact isolation procedures and the proper application of the Personal Protective Equipment to be utilized when assisting residents on isolation precautions **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents on isolation precautions may have potentially been affected. A 100% review of all residents on isolation will be conducted to identify any staff members entering isolation rooms without the appropriate required PPE. Any/all negative findings related to improper use of PPE will be corrected at time of discovery and one-on-one inservice training will be completed with each employee. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Infection Control policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the DON and/or Regional Nurse Consultant on the infection Control Policy and procedure to include the standard for isolation precautions, proper application and removal of PPE and hand washing to prevent the spread or infections before leaving all isolation rooms.	

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F 880	Continued From page 10 (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure an effective infection control program for one of 31 Residents, Resident #62. CNA #1 failed to wear the appropriate PPE (personal protective equipment) when providing care to Resident #62. Resident #62 was on contact isolation.	F 880	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will perform random weekly audits of all resident requiring isolation to monitor for appropriate use of PPE with all residents in isolation. Any/all negative findings will be corrected at the time of discovery and disciplinary action will be taken as warranted. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: 07/06/18**	

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The findings included:

Resident #62 had been re-admitted to the facility 03/28/18. Diagnoses included, but were not limited to, VRE (vancomycin resistant enterococci), heart failure, essential hypertension, hypothyroidism, major depressive disorder, generalized anxiety disorder, and bipolar disorder.

Section C (cognitive patterns) of the Resident's significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 04/13/18 included a BIMS (brief interview for mental status) summary score of 15. Section G (functional status) was coded to indicate the Resident did not have any limitation in range of motion in the upper or lower extremity.

The Resident currently had an order for contact precautions due to VRE. This order was dated 05/12/18.

On 05/22/18 at approximately 11:55 a.m., the surveyor observed CNA (certified nursing assistant) #1 in the Residents room. This CNA did not have on any PPE. CNA #1 was observed by the surveyor moving the Resident's over the bed table around using their bare hands. CNA #1 was observed washing their hands prior to leaving the Residents room.

Upon exiting the room, the surveyor asked CNA #1 about their lack of PPE. CNA #1 verbalized to the surveyor that he had gloves on but had already removed them and thrown them away. When asked about touching and moving the Residents over the bed table with their bare

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495152	A. BUILDING _____ B. WING _____	05/24/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL TAZEWELL	121 BEN BOLT AVENUE TAZEWELL, VA 24651

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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hands. CNA #1 stated he did not want to touch the over the bed table with the gloves on.

Per the CDC (centers for disease control and prevention) website https://www.cdc.gov/HAI/organisms/vre/vre.html accessed 05/23/18 "VRE is often passed from person to person by the contaminated hands of caregivers. VRE can get onto a caregiver's hands after they have contact with other people with VRE or after contact with contaminated surfaces. VRE can also be spread directly to people after they touch surfaces that are contaminated with VRE. VRE is not spread through the air by coughing or sneezing..."

The facility administrator was notified of the above issues on 05/22/18 at approximately 1:15 p.m.

The administrator provided the surveyor with a copy of the facility policy/procedure regarding contact precautions on 05/22/18 this policy/procedure read in part "...Gloves and Handwashing...In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile) when entering the room...After removing gloves and washing hands, do not touch potentially contaminated environmental surfaces or items in the resident's room...."

On 05/22/18 at approximately 2:15 p.m., the surveyor interviewed the infection control nurse LPN (licensed practical nurse) #2. When asked if the staff should be wearing gloves in a Residents room that was on contact isolation due to VRE. LPN #2 stated yes.

No further information regarding this issue was

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F 880	Continued From page 13 provided to the survey team prior to the exit conference.	F 880		