PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495301	B, WING		С	
	THE TAX TO SHEET THE VALUE OF THE PER	450301	B. WING _		08/23/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
UEDITACE	THAT FRONT BOYAL			400 WEST STRASBURG ROAD		
MERITAGE	HALL FRONT ROYAL			FRONT ROYAL, VA 22630		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG		BE COMPLETION	
E 000	Initial Comments		E	000		
F 550 SS=E	survey was conducte 08/23/18. The facility substantial compliance Requirement for Long An unannounced Emsurvey was conducte 08/23/18. This facility CFR Part 483.73, Re Care Facilities. Resident Rights/Exer CFR(s): 483.10(a)(1)(1)(1)(1)(2)(2)(3)(3)(4)(4)(4)(4)(4)(4)(4)(4)(4)(5)(4)(5)(4)(5)(4)(5)(4)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)(6)	was found to be in the with 42 CFR Part 483.73, g-Term Care Facilities. Tergency Preparedness d 08/22/18 through is in compliance with 42 quirement for Long-Term  raise of Rights (2)(b)(1)(2)  Rights. Ight to a dignified existence, and communication with and did services inside and cluding those specified in  thy must treat each resident and in an environment that the or enhancement of his or tognizing each resident's lity must protect and the resident.  Sility must provide equal the regardless of diagnosis, or payment source. A facility aintain identical policies and	F	Corrective Action(s): C.N.A. #1 involved in feeding residents #3 & #24 has been inserviced on reside. Rights and Dignity regarding sitting and not standing while feeding residents and using a napkin to clean food off resident faces and not a spoon. A facility Incide & Accident form has been completed for this incident.  An Incident & Accident form was completed for the incident involving resident #35 who had their meal tray so down in front of them and did not rece feeding assistance after her tray was se up in front her.  Identification of Deficient Practice(s and Corrective Action(s): All other residents may have the potentially been affected. The Administrator and DON will assess the dining experience and process for meadelivery in the dining room to establis	at it	
	practices regarding tr	ansfer, discharge, and the		formal tray set up, delivery and reedil	g	
				formal tray set up, delivery and reedil	g	
	residents regardless	under the State plan for all		assistance process to ensure all staff a providing a dignified dining experien	ie	
	§483.10(b) Exercise (			and providing assistance with their m trays in a timely manner.	eal	
				2000 C C C C C C C C C C C C C C C C C C		
ABORATORY I	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE	B 07800	TITLE	(X6) DATE	

Any deficiency statement ending with an asterisk (\*) benotes a deficiency which the institution may be excused from correcting providing it is determined to other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are deposited so day 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 1.

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. program participation.

Facility ID: VA0101

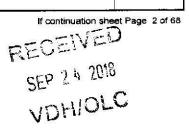
PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	and the second and th	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495301	B. WING		C 08/23/2018	
	ROVIDER OR SUPPLIÉR E HALL FRONT ROYAL	10000 100 1000 100 1000		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 550	rights as a resident of or resident of the Unit §483.10(b)(1) The fact resident can exercise interference, coercior from the facility.  §483.10(b)(2) The refree of interference, creprisal from the facility and to be supplexercise of his or her subpart.  This REQUIREMENT by:  Based on observation document review and was determined that provide a dignified di 31 residents in the sufference and subpart.  1. The facility staff fare Resident #3 during it (Certified nursing assigned feeding the resident and food from the resident.  3. The facility staff fare immediately after platter resident. On 8/2	right to exercise his or her fithe facility and as a citizen ted States.  cility must ensure that the his or her rights without in, discrimination, or reprisal sident has the right to be exercison, discrimination, and ity in exercising his or her forted by the facility in the rights as required under this if is not met as evidenced on, staff interview, facility in delinical record review, it the facility staff failed to ming experience for three of curvey sample, Residents #3, willed to provide dignity for sunch on 8/21/18. CNA sistant) #1 stood while a portion of lunch.  Called to provide dignity for lunch on 8/21/18. CNA #1 he resident a portion of lunch sident's lips with a spoon.  Called to feed Resident #35 and the lipid for the sident #35 and	F 556	Systemic Change(s): Facility policy and procedures were reviewed. No changes are warranted this time. The DON and/or Social Services will inservice all staff on the facility policy and procedure regarding resident rights and dignity. The inserwill also cover the procedure for propential tray delivery and assistance to ensure all residents are served in a time manner and receive meal assistance as same table.  Monitoring: The DON and Administrator are responsible for compliance. The DO Administrator and/or designee will complete the 3 meal pass audit week monitor for compliance. All negative findings will be corrected at the time discovery. The audit findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facilipolicy, procedure, or practice.  Completion Date: 10/1/18	ng vice oper mely at the N or cly to e c of c	

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Event ID: 6RF911

Facility ID: VA0101



#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/04/2018 FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 495301 B. WING 08/23/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD HERITAGE HALL FRONT ROYAL FRONT ROYAL, VA 22630 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 550 | Continued From page 2 F 550 The findings include: 1. The facility staff failed to provide dignity for Resident #3 during lunch on 8/21/18. CNA (Certified nursing assistant) #1 stood while feeding the resident a portion of lunch. Resident #3 was admitted to the facility on 2/18/05. Resident #3's diagnoses included but were not limited to severe intellectual disabilities. legal blindness and difficulty swallowing. Resident #3's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 8/7/18, coded the resident's cognitive skills for daily decision-making as severely impaired. Section G coded Resident #3 as requiring extensive assistance of one staff with eating. On 8/21/18 at 12:20 p.m., CNA #1 was observed feeding Resident #3 and another resident sitting across the table in the restorative dining room. CNA #1 stood while alternating bites of food to each resident until another CNA came in to feed Resident #3. On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked what should be done to provide a dignified dining experience. LPN #5 stated, "We want to make sure we tell them what there is to eat. Give them as many choices as we can. Offer everything. We don't want to do too big of a bite so that creates less of a mess. Conversation." When asked where staff should

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be positioned in relation to a resident he or she is feeding, LPN #5 stated, "Sitting next to them."

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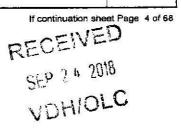
PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
		495301	B. WING_			C 8/23/2018	
	ROVIDER OR SUPPLIER  HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP COD 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		W 20120 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 550	should be done to pri experience. CNA #1 restorative dining; an helped they come ov asked where she sho feeding a resident, C is right there, I sit bes Resident #3's compn 8/6/18 failed to docur the above concern.  On 8/22/18 at 6:15 p. staff member) #1 (the (the director of nursir nurse consultant) we findings.  The facility policy title documented, "3. Res themselves will be fe comfort and dignity fo over residents while  No further informatio  2. The facility staff fa Resident #24 during stood while feeding t and food from the res  Resident #24 was ac 3/24/11. Resident #2 were not limited to di posture and high blo most recent MDS (m	m., an interview was #1. CNA #1 was asked what ovide a dignified dining stated, "That's why we have lybody that needs to be er and help us." When ould be positioned when NA #1 stated, "If somebody	F5	50			

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Event ID: 6RF911

Facility ID: VA0101



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			1 1000 50	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495301	B. WNG_		a	C 8/23/2018
	ROVIDER OR SUPPLIER E HALL FRONT ROYAL	-		STREET ADDRESS, CITY, STATE, ZIP COR 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 550	skills for daily decis impaired. Section (requiring extensive eating.  On 8/21/18 at 12:20 feeding Resident #2 across the table in CNA #1 stood while each resident until a the other resident. #1 was observed so Resident #24's lips  On 8/22/18 at 1:38 conducted with LPN LPN #5 was asked provide a dignified stated, "We want to there is to eat. Giv can. Offer everythibig of a bite so that Conversation." Whe positioned in relifeeding, LPN #5 stated, "I was asked from a resident's fanapkin. If they nee #5 was asked how removed from her fistated, "I guess like On 8/22/18 at 2:12 conducted with CN should be done to	ded the resident's cognitive ion-making as severely coded Resident #24 as assistance of one staff with the p.m., CNA #1 was observed 24 and another resident sitting the restorative dining room. In alternating bites of food to another CNA came in to feed the process of the process of the process food from with the spoon.  In an interview was a like the process of a mess. In the process of a mess, we have a many choices as we have the process of a mess. In asked where staff should action to a resident he or she is ated, "Sitting next to them." In how food should be removed the process of the process o	F 5	50		
	restorative dining;	t1 stated, "That's why we have anybody that needs to be over and help us." When				8

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION			COMP	(X3) DATE SURVEY COMPLETED	
	495301	B. WNG	<u>u</u>		C /23/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL FRONT ROYAL		1	STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
PREFIX (EACH DEFICIENCY N	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOTTAG CROSS-REFERENCED TO THE APPLICATION OF CORRECT PROPERTY.		(X5) COMPLETION DATE
is right there, I sit beside mouth when stuff is all of she wipes the resident's use their protective cover. When asked if she coulstated, "We can use national of this surveyor's observas wiping her face."  Resident #24's compress of 6/28/18 failed to docume the above concern.  On 8/22/18 at 6:15 p.m. staff member) #1 (the asterior of nursing) nurse consultant) were findings.  No further information volumed as a severely impaired. See the sident was a severely impaired.	d be positioned when A #1 stated, "If somebody e them and wipe their over it." When asked how is mouth, CNA #1 stated, "I er (a clothes cover)." duse a napkin, CNA #1 pkins." When made aware vation, CNA #1 stated, "I hensive care plan dated ient information regarding ASM (administrative administrator), ASM #2 and ASM #3 (the regional made aware of the above was presented prior to exit.  If to feed Resident #35 and the reight minutes.  If the positioned when a positioned is diagnoses included but lentia, right eye blindness g. Resident #35's most	F 56	50		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495301	B. WING		0	8/23/2018
	ROVIDER OR SUPPLIER E HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	, 602012010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 550	covered meal tray in resident was not off for eight minutes.  On 8/22/18 at 1:38 producted with LPN LPN #5 was asked to offer assistance to a has been placed in stated, "If there is for shouldn't be waiting describe "too long," they shouldn't be waiting describe "too long," they shouldn't be ward and someone then return; other the them." When asked required assistance placed in front of he receiving assistance on 8/22/18 at 2:12 producted with CNA long it should take to resident after a mea of him or her. CNA there."	p.m., a CNA placed a front of Resident #35. The ered assistance with the meal co.m., an interview was (licensed practical nurse) #5. Inow long it should take to president after a meal tray front of him or her. LPN #5 and sitting in front of them they too long." When asked to LPN #5 stated, "I would say aiting more than five minutes, where you put the tray needs a straw so you get that an that you should be feeding how she would feel if she with eating and a meal was a for eight minutes before the LPN #5 stated, "Hungry."  D.m., an interview was a #1. CNA #1 was asked how to offer assistance to a litray has been placed in front #1 stated, "When we place it orehensive care plan dated turnent information regarding	F 55			
	staff member) #1 (the director of nursi	e.m., ASM (administrative e administrator), ASM #2 ng) and ASM #3 (the regional ere made aware of the above				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00		NSTRUCTION	(X3) DATE S	
		495301	B. WING_	**		08/2	23/2018
	ROVIDER OR SUPPLIER E HALL FRONT ROYAL			400 W	ET ADDRESS, CITY, STATE, ZIP CODE JEST STRASBURG ROAD NT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<b>«</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550 F 584 SS=D	Continued From pagifindings.  No further information Safe/Clean/Comforts CFR(s): 483.10(i)(1) §483.10(i) Safe Environment The resident has a recomfortable and hor but not limited to recomports for daily live. The facility must professible of the same of the	on was presented prior to exit.  able/Homelike Environment (-(7))  ironment. ight to a safe, clean, melike environment, including the environment, including the safely.  ovide- index, comfortable, and ent, allowing the resident to small belongings to the extent suring that the resident can invices safely and that the the facility maximizes resident does not pose a safety risk. exercise reasonable care for the resident's property from loss execution and maintenance to maintain a sanitary, orderly, erior;	F	550		som 35's ence to ng the n the for e(s) s the meal esident t up, ocess to nified	191/15
	in good condition; §483.10(i)(4) Privat resident room, as s	bed and bath linens that are e closet space in each pecified in §483.90 (e)(2)(iv); uate and comfortable lighting			Services will inservice nursing and dietary staff on the facility policy procedure for providing a homelik dining experience during all meals inservice will cover removing all plates, utensils and drinks from th serving tray when delivery resider to ensure all residents are receiving homelike dining experience.	d and and se s. The meal e nt meals	
	Tables and the second s						

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STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495301	B. WING_			1	C /23/2018	
	ROVIDER OR SUPPLIER  HALL FRONT ROYAL	<b>.</b>		400 V	ET ADDRESS, CITY, STATE, ZIP CODE WEST STRASBURG ROAD NT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 584	§483.10(i)(6) Comfor levels. Facilities initial 1990 must maintain a 81°F; and §483.10(i)(7) For the sound levels. This REQUIREMENT by: Based on observation document review and was determined that provide a homelike of 31 residents in the state and the s	table and safe temperature lly certified after October 1, a temperature range of 71 to  maintenance of comfortable  is not met as evidenced  on, staff interview, facility d clinical record review, it the facility staff failed to ining experience for three of urvey sample, Residents #3,  d to provide a homelike Residents #3, #24 and #35  /18. The residents were in serving trays.  mitted to the facility on B's diagnoses included but evere intellectual disabilities, difficulty swallowing. ecent MDS (minimum data essment with an ARD ce date) of 8/7/18, coded the ekills for daily severely impaired. Section G is requiring extensive	F	584	Monitoring: The DON and Administrator are responsible for compliance. The DO unit managers and/or designee will complete the 3 meal pass audit were monitor for compliance. All negatifindings will be corrected at the tindiscovery. The audit findings will reported to the Risk Management Committee for review. Aggregate findings will be reported to the Quantities for review, analysis, a recommendations of change in fapolicy, procedure, or practice.  Completion Date: 10/1/18	kly to ve ne of be A		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	13(3) - 24 100000,19223	TPLE CONSTRUCTION	0	(3) DATE SURVEY COMPLETED
		495301	B. WING	250000		C <b>08/23/2018</b>
	ROVIDER OR SUPPLIER  E HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP COI 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	DE	00/23/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 584	assessment with an Adate) of 6/29/18, code skills for daily decision impaired. Section Grequiring extensive as eating.  Resident #35 was add 12/18/15. Resident #were not limited to de and difficulty swallowing recent MDS (minimum assessment with an Adate) of 7/13/18, code as severely impaired. #35 as requiring extensive with eating.  On 8/21/18 at 12:13 places with eating.  On 8/21/18 at 2:12 places with eating of the eating room on 8/21/1 some residents were softens were not. CNA supposed to come off been a little nervous been	nimum data set), a quarterly ARD (assessment reference ed the resident's cognitive n-making as severely coded Resident #24 as assistance of one staff with mitted to the facility on 35's diagnoses included but amentia, right eye blindnessing. Resident #35's most in data set), a quarterly ARD (assessment reference ed the resident's cognition. Section G coded Resident insive assistance of one staff.  a.m., a dining observation restorative dining room. Idents #3, #24 and #35 their g trays and did not remove ing the residents with their esidents' meal plates were sent the serving trays.  m., an interview was certified nursing assistant) in the restorative served meals on trays and af1 stated, "They were the trays. We might have because you guys are ed, they don't touch their	F	584		

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		495301	B. WING	er ill Wares in	08/23/2018
	ROVIDER OR SUPPLIER		400	REET ADDRESS, CITY, STATE, ZIP CODE  WEST STRASBURG ROAD  ONT ROYAL, VA 22630	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 584	remove meals from s "It's nice dining; more On 8/22/18 at 6:15 p staff member) #1 (th (the director of nursin nurse consultant) we findings.  The facility documen Homelike Environme are provided with a s homelike environme their personal belong	sked why staff is supposed to serving trays, CNA #1 stated, e like being at home."  .m., ASM (administrative e administrator), ASM #2 ng) and ASM #3 (the regional are made aware of the above at titled, "Quality of Lifeent" documented, "Residents safe, clean, comfortable and ant and encouraged to use gings to the extent possible."	F 584		191/18
F 623 SS=D	Notice Requirements CFR(s): 483.15(c)(3) §483.15(c)(3) Notice Before a facility transresident, the facility (i) Notify the resident representative(s) of the reasons for the r	e before transfer.  sfers or discharges a must- t and the resident's the transfer or discharge and move in writing and in a er they understand. The copy of the notice to a e Office of the State abudsman.  ons for the transfer or ident's medical record in ragraph (c)(2) of this section; tice the items described in his section.	F 623	Corrective Action(s): Resident #96's resident representative been notified that the facility failed to provide a discharge/transfer notice for resident's transfer to the hospital on 8/10/18.  Identification of Deficient Practices/Corrective Action(s): All other residents discharged and/or transferred from the facility may have been affected. The Social Services Director and/or Admissions Director conduct a 100% audit of all residents have been discharged and/or transfer in the past 60 days. Residents identifications to the residents' responsible party and the sombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding.	e will who red ied at overy

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00	PLE CONSTRUCTION  G	` СОМІ	SURVEY PLETED
		495301	B. WING _		08/2	23/2018
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		0.2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y 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	(X5) COMPLETION DATE
F 623	(c)(8) of this section discharge required made by the facility resident is transfer (ii) Notice must be before transfer or (A) The safety of in be endangered und this section; (B) The health of in be endangered, und this section; (C) The resident's allow a more immedunder paragraph (C) An immediate to required by the resunder paragraph (C) A resident has days.  §483.15(c)(5) Continuities especified in must include the formation of the endangered or discluding the name and telephone num receives such requite obtain an appead completing the form hearing request; (v) The name, additional to transferred or discluding the formation of the endangered or discluding the name and telephone num receives such required to obtain an appead completing the formation of the endangered or discluding request; (v) The name, additional control of the endangered or discluding the formation of the endangered or discluding the formation of the endangered or discluding the name, additional control of the endangered or discluding the formation of the endangered or discluding the endanger	field in paragraphs (c)(4)(ii) and in, the notice of transfer or under this section must be at least 30 days before the red or discharged.  In made as soon as practicable discharge whendividuals in the facility would der paragraph (c)(1)(i)(C) of adviduals in the facility would der paragraph (c)(1)(i)(D) of adviduals in the facility would der paragraph (c)(1)(i)(D) of adviduals in the facility would der paragraph (c)(1)(i)(D) of an ealth improves sufficiently to advide transfer or discharge, exit(1)(i)(B) of this section; ransfer or discharge is ident's urgent medical needs, exit(1)(i)(A) of this section; or not resided in the facility for 30 dents of the notice. The written paragraph (c)(3) of this section allowing: transfer or discharge; which the resident is	F 62	Systemic Change(s): Facility policy and procedures have reviewed. No revisions are warrante this time. The Administrator and/or Regional Nurse Consultant will inset the facility's social worker(s) and not administration on the requirement the resident's responsible party and the sombudsman be notified of resident discharges/transfers.  Monitoring: The Social Services Director will be responsible for maintaining compliant The Social worker, and/or Admission Director will conduct chart audits we of all residents who have been dischand/or transferred from the facility. Any/all negative findings and or errowill be corrected at time of discovery disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendatic for change in facility policy, proceduland/or practice.  Completion Date: 10/1/18	ed at rvice ursing at a state  nce. ns eekly arged ors y and	191118

Facility ID: VA0101

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PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	10)	TIPLE CONSTRUCTION	CON	(X3) DATE SURVEY COMPLETED	
		495301	B. WING			C /23/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 623	and developmental disabilities, the matelephone number the protection and developmental dis C of the Developmental disorder or related email address and agency responsible advocacy of individes tablished under for Mentally III Individes the information in effecting the transmust update the reas practicable one becomes available §483.15(c)(8) Note In the case of facilities administrator of written notification to the State Surve State Long-Term C the facility, and the well as the plan for relocation of the re483.70(I). This REQUIREMED by:  Based on staff into the protection of the reason	ombudsman; cility residents with intellectual all disabilities or related illing and email address and of the agency responsible for advocacy of individuals with abilities established under Part mental Disabilities Assistance act of 2000 (Pub. L. 106-402, C. 15001 et seq.); and cility residents with a mental disabilities, the mailing and I telephone number of the e for the protection and duals with a mental disorder the Protection and Advocacy viduals Act.  Inges to the notice.  In the notice changes prior to fer or discharge, the facility ecipients of the notice as soon the the updated information		623			

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Event ID: 6RF911

Facility ID: VA0101

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDII	PPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C	
		495301	B. WING	A 1977	08/	23/2018
	NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP CO 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 623	failed to provide w (resident represent ransfer for one of sample, Resident Resident #96 trans 8/10/18. The facil notification of the resident's represe The findings included Resident #96 was 12/20/16. Resident were not limited to urinary tract infect recent MDS (minitial assessment with a date) of 6/6/18, cocognitively intact.  Review of Resident was to 8/10/18 due to a fer Further review of failed to reveal with was provided to the On 8/22/18 at 1:30 conducted with LF (one of the nurses #96's hospital transferred to the	ritten notification to the RR stative) for a facility-initiated 31 residents in the survey #96.  sferred to the hospital on ity staff failed to provide written facility-initiated transfer to the notative.	F 6:	23		
	go to the hospital. belongings." Whe	lly they don't come in to us; they If they come in to get their en again asked if she provides N #5 stated, "I don't do that."				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495301	B. WING		08	C /23/2018	
	PROVIDER OR SUPPLIER  SE HALL FRONT RO	YAL		STREET ADDRESS, CITY, STATE, ZIP ( 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO  (EACH CORRECTIVE ACTION  CROSS-REFERENCED TO THE  DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 623	requested docume #96's hospital transinter-facility or intraconsent for inter-facility or intraconsent for inter-facility or inter-facility or intraconsent for inter-facility or inter-facility to I understand that I at (name of facility) to I understand the respace to be filled or signature line for the On 8/22/18 at 4:56 conducted with LP called but could not representative what to the hospital on 8 later that day, the representative that transferred to the Resident #96's re	age 14  p.m., LPN #5 presented other entation regarding Resident sfer and a blank consent for a facility transfer form. The acility or intra-facility transfer "Resident: Date: Date: I have been fully into regarding transfers. I am being transferred from the being transfer to be (blank space to be filled out). It is ason for transfer to be (blank space) and resident and/or RR.  In p.m., another interview was the resident and/or RR.  In p.m., another interview was the resident was transferred streach Resident #96's en the resident was transferred streach Resident #96's en the resident was transferred streach Resident #96 had been to spital. LPN #5 stated that representative came to the esident #96 had been to spital. LPN #5 stated or interafacility form back to the aff an update on the resident's asked if she ever attempted to so representative the consent or intra-facility form, LPN #5. When asked if she filled out the form with Resident #96 to #5 stated she did not.  In p.m., ASM (administrative the administrator), ASM #2 sing) and ASM #3 (the regional were made aware of the above	F6	23			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495301	B. WING		C 08/23/2018
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	1 00/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 623	Resident" failed to regarding the abov	ent titled, "Discharging the document information e concern.	F 623	3	
	Develop/Implement CFR(s): 483.21(b) (S483.21(b) (1) The implement a complement a complement a complement are plan for each resident rights set of \$483.10(c)(3), that objectives and time medical, nursing, an eeds that are ider assessment. The odescribe the follow (i) The services that or maintain the resphysical, mental, a required under \$48 (ii) Any services that under \$483.24, \$48 provided due to the under \$483.10, incomplement under \$480.10 (iii) Any specialized rehabilitative services provide as a result recommendations. findings of the PAS rationale in the resident's representations.	chensive Care Plans facility must develop and rehensive person-centered resident, consistent with the forth at §483.10(c)(2) and includes measurable of the strames to meet a resident's and mental and psychosocial attified in the comprehensive comprehensive care plan must ing - at are to be furnished to attain ident's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not a resident's exercise of rights and the right to refuse as.10(c)(6). I services or specialized ses the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the	F 656	Corrective Action(s): Resident #6's comprehensive care has been reviewed and revised to rappropriate goals and interventions approaches to address the resident' specific Oxygen usage and treatmeneds. A Facility Incident & Accide Form was completed for this incident Resident #96's comprehensive care and C.N.A. has been reviewed and revised to reflect appropriate goals interventions and approaches to ad the resident's specific medical and treatment needs to include the use appropriate personal protective equivalent when entering a resident room who Isolation. A Facility Incident & Accomprehensive care plans and C.N. All residents may have potentially affected. A 100% review of all comprehensive care plans and C.N. care plans will be conducted by the ADON, RCC and/or designee to id residents with inaccurate or incomprehensive and C.N.A. care plans Resident identified with inaccurate incomplete care plans will have the plan reviewed and updated to reflect current interventions and appropriate approaches to address their medical treatment needs. A Facility Incident Accident Form will be completed for incident identified.	effect s and s nt ent ent ent ent ent eplan and dress of cipment is on cident ent.  es ceen A. DON, entify elete uns. or ir care et their te and and ad

PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL  (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 16 desired outcomes.  (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.  (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.  This REQUIREMENT is not met as evidenced by:  STREET ADDRESS, CITY, STATE, ZIP CODE  400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630  F 656  Systemic Changes: The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the requirements set forth in paragraph (c) of this section.  This REQUIREMENT is not met as evidenced by:			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	9750 MO 2020 2010 CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 656  Continued From page 16 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.  This REQUIREMENT is not met as evidenced by:  SUMMARY STATEMENT OF CERECTION SHOULD BE PROVIDER'S PLAN OF CORRECTION (CAS) PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  PREFIX TAG  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DETICUTES ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DETICUTES ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DETICUTES ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DETICUTES TO THE APPROPRIATE DEFICIENCY)  F 656  Systemic Changes: The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.			495301	B. WING _		08		
F 656 Continued From page 16 desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.  This REQUIREMENT is not met as evidenced by:  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Systemic Changes:  The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.					400 WEST STRASBURG ROAD			
desired outcomes.  (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.  (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.  This REQUIREMENT is not met as evidenced by:  Systemic Changes:  The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	SHOULD BE	(X5) COMPLETION DATE	
Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for two of 31 residents in the survey sample, Residents #6, #11, and #96.  1. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #6.  3. The facility staff failed to implement Resident #96's comprehensive care plan for contact precautions.  The findings include:  1. The facility staff failed to implement the comprehensive care plan for the administration of oxygen for Resident #6.  Resident #6 was admitted to the facility 4/20/16 with diagnoses, which included but were not limited to: anxiety disorder, arthritis, depression,	F 656	desired outcomes (B) The resident's future discharge. I whether the reside community was as local contact agen entities, for this pu (C) Discharge pla plan, as appropria requirements set is section. This REQUIREME by: Based on staff int review, and clinica failed to implement for two of 31 resid Residents #6, #11  1. The facility staff comprehensive ca oxygen for Reside  3. The facility staff #96's comprehens precautions.  The findings inclu- 1. The facility staff comprehensive ca oxygen for Reside Resident #6 was a with diagnoses, w	preference and potential for Facilities must document ent's desire to return to the assessed and any referrals to ncies and/or other appropriate arpose. In the comprehensive care ate, in accordance with the forth in paragraph (c) of this entire in paragraph (c) of this entire in the comprehensive care plant and record review, the facility staff of the comprehensive care plant ents in the survey sample, and #96.  If failed to implement the are plan for the administration of ent #6.  If failed to implement Resident sive care plan for contact  de:  If failed to implement the are plan for the administration of ent #6.  Admitted to the facility 4/20/16 hich included but were not		Systemic Changes: The facility Policy and Proced been reviewed and no change warranted at this time. The nu assessment process as evidence 24 Hours Report and document the medical record and physic will be used to develop and recomprehensive plans of care. IDT and the DON will be inset the regional nurse consultant development, revision and implementation process of inccare plans.  Monitoring: The RCC and DON are responsaintaining compliance. The RCC will perform care plan a coinciding with the care plan monitor for compliance. Any findings will be reported to the RCC for immediate correction findings of the interdisciplina audit will be reported to the Cassurance Committee for revanalysis, and recommendatio change in facility policy, progand/or practice.	s are arsing ced by the intation in cian orders evise The RCC, erviced by on the dividualized  onsible for DON and/or audits weekly calendar to /al! negative ne DON / n. Detailed ary team's Quality view, ns for		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495301	B. WING			C	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO. 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		23/2018	
(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 CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 656	assessment, an an assessment referer resident as scoring interview for menta resident was cognit decisions. In Secti Procedures, and Procedures, and Procedures, and Procedures, and Procedures of the look bath the comprehensive documented in part SOB (shortness of of COPD (chronic or general term for or disease that is usus emphysema and of "Approaches" documented."  Observation was mat 8:06 a.m. The recoxygen on via the recoxygen on via the recoxygen concent was set at 4L/min (A second observation 8/22/18 at 9:48 the bed with her ox connected to an oxygen concentrate	DS (minimum data set) nual assessment, with an nce date of 5/28/18, coded the a "15" on the BIMS (brief I status) score, indicating the tively intact to make daily on O - Special Treatments, rograms, the resident was sed oxygen within the last 14 ck period.  e care plan dated, 5/30/18, t, "Problem/Need: At risk for breath) due to DX (diagnosis) obstructive pulmonary disease chronic, nonreversible lung ally a combination of foronic bronchitis) (1)." The timented in part, "O2 [oxygen]  ande of Resident #6 on 8/22/18 tesident was in bed with her the asal cannula (plastic tube with ert into the nose) connected to rator. The oxygen concentrator liters/minute).  Son was made of Resident #6 a.m. The resident was still in tygen on via the nasal cannula tygen concentrator. The or was set at 4L/min.	F 6	56			
	was observed with #3. LPN #3 verified	a.m., the oxygen concentrator LPN (licensed practical nurse) I that the oxygen flow meter LPN #3 stated he did not have			10 feet 10 mg	11 15	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		25.00	PLE CONSTRUCTION  IG	CON	(X3) DATE SURVEY COMPLETED	
		495301	B. WING _		The second secon	C /23/2018
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CO 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	any residents press she probably is sup #3 went to the clini resident was to be order.  The physician orde "O2 (oxygen) @ (a nasal cannula at H per resident reque (nasal cannula) QA  The August 2018 " Record" (TAR) doc order. The TAR do the oxygen every e August.  There was no doct 8/22/18.  An interview was o 8/22/18 at 1:53 p.r the care plan, LPN plan of care to ma met." When asked #5 stated, "Yes, it  An interview was o (administrative sta nursing, and LPN nursing, on 8/22/1 purpose of the car establish the goals the staff will be ab their (the resident' care plan should be	cribed for 4 liters. He stated oposed to be on 2 liters. LPN cal record and verified the on 2L/min per the physician or dated, 8/7/18, documented, at) 2L/m (liters per minute) via lS (hours of sleep - bedtime) st. Remove O2 at 2L/min NC AM (every morning)."  Treatment Administration cumented the above physician ocumented the administration of evening for each evening in umented nurse's notes for sonducted with LPN #5 on m. When asked the purpose of I #5 stated, "It's to provide a ke sure all of their needs are I if it should be followed, LPN should be."  conducted with ASM at 2:44 p.m. When asked the re plan, ASM #2 stated, "It's to so of the resident and so that all le to provide the care to reach so goals." When asked if the per followed, ASM #2 stated, o longer appropriate. Then it	F 65	56		

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	35 23	PLE CONSTRUCTION  G	COV	(X3) DATE SURVEY COMPLETED	
		495301	B. WING	-	88	C /23/2018	
	NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP 0 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 656	Person-Centered' comprehensive, pincludes measural meet the resident functional needs if for each resident, are derived from a information gathe comprehensive as comprehensive, poscribe the servattain or maintain practicable physic well-being."  According to Function well-being. According to Function well-being. According to Function and Williams and goals. It compactions to the care The nursing information about and goals. It compacts and is used to direvise and update there are change with new orders	"Care Plans, Comprehensive documented in part, "A terson - centered care plan that ble objectives and timetables to be physical, psychological and sideveloped and implemented and implemented and implemented are plan interventions a thorough analysis of the red as part of the sessment8. The terson-centered care plan will: but it is that are to be furnished to the resident's highest real, mental and psychosocial damentals of Nursing Lippincott wins 2007 pages 65-77 written care plan serves as a roll among health care team ps ensure continuity of grare plan is a vital source of the patient's problems, needs, tains detailed instructions for als established for the patient ect careexpect to review, the care plan regularly, when it in condition, treatments, and "	F 65	6			
	administrator, AS ASM #3, the region (licensed practical director of nursing	off member (ASM) #1, the M #2, the director of nursing, conal nurse consultant, LPN II nurse) #1, the assistant g, and ASM #5, the administrator nade aware of the above 18 at 6:00 p.m.					

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Event ID: 6RF911

Facility ID: VA0101

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VDH/OLC

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- am nove properties	FIPLE CONSTRUCTION NG		E SURVEY IPLETED
		495301	B. WING			C <b>23/2018</b>
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	OULD BE	(X5) COMPLETION DATE
F 656		ige 20 ion was provided prior to exit.	F 6	56		
		ery of Medical Terms for the er, 5th edition, Rothenberg and 4.				
		failed to implement Resident ve care plan for contact				
	12/20/16. Residen were not limited to urinary tract infection recent MDS (minimassessment with all	admitted to the facility on t #96's diagnoses included but convulsions, diabetes and on. Resident #96's most num data set), a quarterly in ARD (assessment reference ded the resident as being				
	a physician's order	t #96's clinical record revealed dated 8/15/18 for contact BL (Extended-spectrum				
	6/11/18 documente	nprehensive care plan dated ed, "CI (Contact isolation) (2) ESBL in urineApproaches:				
		A (certified nursing assistant) document information solation.				
	Resident #96's roo beverage. CNA #1	a.m., CNA #1 was observed in m, assisting the resident with a was not wearing a gown, NA #1 did not wash her hands				

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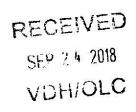
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY MPLETED		
	495301		B. WING			C 08/23/2018	
NAME OF F	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	23/2016	
HERITAGE HALL FRONT ROYAL				400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUNDS OF THE APPRIOR OF THE	JLD BE	(X5) COMPLETION DATE	
F 656	Defore leaving the r On 8/22/18 at 1:38 conducted with LPN LPN #5 was asked LPN #5 stated, "To sure we hit all areas make sure their nee asked how CNAs a care plans, LPN #5 plan for the CNAs the closet door. Each plans can follow and repo LPN #5 was asked entering and when room. LPN #5 state protective gear which put on whatever is a Knock on the door a I leave, once I have remove my stuff at my hands to leave the On 8/22/18 at 2:12 conducted with CNA she should do befor room. CNA #1 state gloves." CNA #1 we before leaving a con stated, "Take it off, the room" When as hands, CNA #1 state On 8/22/18 at 6:15 staff member) #1 (the director of nurs	p.m., an interview was I (licensed practical nurse) #5. the purpose of a care plan. provide a plan of care to make of care for that patient to eds are being met." When and nurses ensure they follow stated, "We have a mini care nat's on the inside of the person has one that the CNA art (verbal shift to shift report)." what she should do before leaving a contact isolation ed, "I'm going to use my ch should be outside the room; suitable for the isolation. ask to enter the room. Before done what I need to do, the door to be able to wash he room."  p.m., an interview was A #1. CNA #1 was asked what are entering a contact isolation ed, "Gown up, mask and as asked what she should do intact isolation room. CNA #1 but it in the isolation carts in ked if she should wash her	F 6	56			

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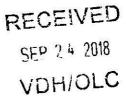
	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495301			C 08/23/2018	
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	0.072.01.010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION	
F 658 SS=D	No further information (1) "Extended-special enzyme that allows to a wide variety of cephalosporins. Barenzyme are known bacteria. ESBL-programe resistant to strough extended spectrum information was obhttps://www.cdc.govts.html  (2) "Healthcare per Contact Precaution all interactions that patient or potentiall patient's environme obtained from the whitps://www.cdc.govs/isolation-guideline (3) "Methicillin-resis (MRSA) causes a rand wound infection bloodstream infection bloodstre	trum ß-lactamase is an bacteria to become resistant penicillin's and acteria that contain this as ESBLs or ESBL-producing oducing Enterobacteriaceae ing antibiotics including cephalosporins." This tained from the website: w/drugresistance/biggest_threa sonnel caring for patients on s wear a gown and gloves for may involve contact with the y contaminated areas in the ent." This information was vebsite: w/infectioncontrol/pdf/guideline es.pdf  stant Staphylococcus aureus ange of illnesses, from skin ins to pneumonia and ons that can cause sepsis and eria, including MRSA, are one on causes of ted infections." This tained from the website: w/drugresistance/biggest_threa	F 656		uiled a	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
	9	495301	B. WING		C	
NAME OF	PROVIDER OR SUPPLIER		SCIENT Monarcac,	STREET ADDRESS, CITY, STATE, ZIP CODE	08/23/2018	
UEDITA!	GE HALL FRONT RO	VA I	400 WEST STRASBURG ROAD			
HERLIAG	AE HALL PHONE HO	ral		FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		BE COMPLETION	
F 658	as outlined by the comust- (i) Meet professional This REQUIREMENT by: Based on staff intered and clinical record of facility staff failed to of practice for one complete, Resident #  A. The facility staff is standards of practice of the physician for Resident #11.  B. The facility staff is standards of practice actual blood sugar of the findings included A. Resident #11 ware 7/21/16 with diagnolimited to: diabetes, depression, anxiety impairment.  The most recent MI assessment, a quarassessment references ident as scoring interview for mental was moderately impactivities of daily livitations. The resident as standards of daily livitations and standards of the complete for mental was moderately impactivities of daily livitations.	al standards of quality.  NT is not met as evidenced erview, facility document review review, it was determined the follow professional standards of 31 residents in the survey entity.  failed to follow professional ce for documenting notification an elevated blood sugar for failed follow professional ce for the documenting the readings for Resident #11.  Es:  s admitted to the facility on eses that included but were not high blood pressure, disorder and mild cognitive and mild cognitive of the facility assessment, with an ence date of 6/20/18, coded the a "12" on the BIMS (brief I status) score, indicating she paired to make cognitive daily dent was coded as requiring nited assistance for her	Fe	accurately document a blood sugar resu on the Medication administration record Resident #11's insulin orders and blood sugar monitoring orders have been reviewed to ensure all medication order accurate. A Facility Incident & Accident Form was completed for these incidents.  Identification of Deficient Practices/Corrective Action(s): All other diabetic residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all diabetic resident's medication orders to identify any residents at risk. All residents identified risk will be corrected at time of discove and an Incident & Accident form will be completed for each negative finding. The attending physicians will be notified of each incorrect medication order.  Systemic Change(s): The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining, transcribing and administering physician ordered medications and treatments per physicia order. Licensed staff will be inserviced the DON and/or regional nurse consulta on the policy & procedure for medication administration to include documenting blood sugars accurately and MD notification for blood sugars above 400 per physician order.	at ry e ne	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495301	B. WING _		ns.	C /23/2018
	PROVIDER OR SUPPLIER  GE HALL FRONT RO	YAL		STREET ADDRESS, CITY, STATE, ZIP C 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 658	"BS (blood sugar) A Novolog (a short ac (subcutaneous) Slice Below 130 = O (uni 131 - 180 = 4 u (un 181 - 240 = 8 u 241 - 300 = 1- u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 400 (medical doctor)."  The June 2018 Med (MAR) documented On 6/26/18 at 4:30 the blood sugar as #2 documented this and the nurse's not documentation of the elevated blood: The comprehensive documented in part Mellitus risk for high predicts her needs thinks she is feeing glucose readings." documented in part orders. BS per order or s/s (signs and sy hypo/hyperglycemia sugars)."  An interview was co 8/22/18 at 6:46 p.m the above order for asked to review the asked if she notified	AC (before) meals w/ (with) eting insulin) (1) SQ ding Scale: ts) its)  D = 20 u & (and) call MD  dication Administration Record the above medication order. p.m., the nurse documented "436." RN (registered nurse) is. Review of the MAR notes es failed to evidence the physician being notified of sugar reading.  E care plan dated, 5/30/18, "Problem/Need: Diabetes in and lows of BS. Resident and intake based on how she vs (versus) actual number of The "Approaches", "Give medications per int. Notify MD of changes in BS	F 65	Monitoring: The DON is responsible for maccompliance. The DON, ADON Unit Manager will conduct Maphysician order reviews weekly residents with insulin and bloomonitoring orders to maintain compliance. Any/all negative will be corrected at time of distriction disciplinary action will be takeneeded. Aggregate findings of audits will be reported to the Cassurance Committee quarters review, analysis, and recommend for change in facility policy, pand/or practice.  Completion Date: 10/1/18	I and/or AR and y for od sugar findings scovery and en as f these Quality ly for endations	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPL	(X3) DATE SURVEY COMPLETED	
c	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	
495301 B. WING 08/23	3/2018	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  400 WEST STRASBURG ROAD  FRONT ROYAL, VA 22630		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658 Continued From page 25 her (the doctor's) communication book." RN #2 further stated, "I've been doing this for a long time. If it's not documented, I may have hit cancel or enter and it disappeared but I know I did it." RN #2 was asked to provide evidence that she documented the notification in the doctor's communication book.  An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 8/23/18 at 8:10 a.m. The blood sugar and nurse's notes were reviewed with ASM #2. When asked if they had found documentation of the notification in the doctor's communication book, ASM #2 stated they had not found it. ASM #2 further stated, "If it's not documented is not done."  An interview was conducted with LPN (licensed practical nurse) #3 on 8/23/18 at 8:20 a.m. When asked if the sliding scale should be followed as written, LPN #3 stated, "Absolutely." When asked where physician notification documented if the blood sugar is greater than 400 and the doctor was notified as ordered, LPN #3 stated, "In the nurse's notes."  On 8/23/18 at 8:56 a.m., LPN #1 presented a document of blood sugars for Resident #11, which was printed on 6/27/18 at 6:32 a.m. The attending physician signed the paper. LPN #1 stated, "We print these out on the 11-7 (11:00 p.m. to 7:00 a.m.) shift for the doctors and nurse practitioners for the days they are coming to the facility." When asked if this document is part of the clinical record, LPN #1 stated, "No, Ma'am."  The facility policy, "Charling and Documentation" documented in part, "All services provided to the resident, progress toward the care plan poals, or		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		500 - 45 COLUMN COLUM	TIPLE CONSTRUCTION  NG	COM	(X3) DATE SURVEY COMPLETED		
		495301	B. WING_		- 1	C 23/2018	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL				STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	1 55	20,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (CACH CORRECTIVE ACTION SHOCK CROSS-REFERENCED TO THE APPROPRIES OF THE APP	JLD BE	(X5) COMPLETION DATE	
F 658	any changes in the functional or psychologoumented in the medical record sho between the interdiresident's condition following information resident medical reobservations. b. Me Treatments or servithe resident's conditionaccidents involving toward or changes objectives."  The following quota Fundamentals of N 237): "The client redocument of the clireceivedBecause team members can assessments or into years after the fact, documentation at the care may have documentation must administrative staff administrator, and Anursing, were made on 8/23/18 at 9:50 a of practice the facili "Lippincott."	resident's medical, physical, psocial condition, shall be resident's medical record. The uld facilitate communication sciplinary team regarding the and response to care2. The in is to be documented in the cord: a. Objective edications administered. c. ideas performed. d. Changes in ition. e. Events, incidents or the resident. f. Progress in the care plan goals and attion is found in Lippincott's ursing 5th edition (2007, page cord serves as a legal ent's health status and care enurses and other healthcare and remember specific erventions involving a client accurate and complete the time of care is essential.	F 6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND MED		IPLE CONSTRUCTION		E SURVEY MPLETED
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	m?setid=cd88e313 d  B. The facility staff is standards of practic actual blood sugar. The July 2018 MAF sliding scale insulin 7/22/18 at 4:30 p.m blood sugar reading dates.  The July 2018 MAF following on each of for 4:30 p.m. bs (bk) Review of the "Vital electronic record fadocumentation of the above dates and time. Review of the nurse failed to evidence disugar readings.  An interview was considered with RN # sugar reading numbers for the blood included in the MAF why it isn't there."	failed follow professional readings for Resident #11.  If documented the order for the above. On 7/7/18, 7/8/18 and there was no documented g. RN # 1 completed all three of the above dates: "scheduled bod sugar) < (less than) 130."  Signs" section of the iled to evidence he blood sugar readings on the	F 65	58		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495301	B. WING			C /23/2018
	PROVIDER OR SUPPLIER	<b>YAL</b>		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 658	8/23/18 at 8:20 a.m blood sugar reading stated, "A box come then populates to the vital signs." When a document the blood #3 stated, "It's prob do that."  The facility policy, "Glucose Level" doc "DocumentationT procedure should rein the resident's me sugar results."  The following quota Fundamentals of No 980) "Procedure: M Skin Puncture15. and record obtained Administrative staff administrator, and A nursing, were made on 8/23/18 at 9:50 a of practice the facilit "Lippincott."	When asked where the gs are documented, LPN #3 es up and you put it there. It he blood sugar section in the asked if a nurse should it sugar as less than 130, LPN ably not in the best interest to Obtaining a Finger stick umented in part, he person performing this ecord the following information dical record:6. The blood tion is found in Lippincott's ursing 5th edition (2007, page easuring Blood Glucose by Share test results with client it values in the client chart."  Imember (ASM) #1, the ASM #2, the director of aware of the above concernation. When asked the standard try uses, ASM #2 stated,	F 6	58		191/18
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3) §483.21(b)(3) Comp The services provid	orehensive Care Plans ed or arranged by the facility, omprehensive care plan,	F 65	Corrective Action(s): Resident #196's attending physician been notified that facility staff failed provide oxygen at the physician order flow rate and that facility staff failed maintain the physician ordered usage schedule. A facility incident and acc form has been completed for this incident.	to ered to e ident	
1						

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	F 72 10		CONSTRUCTION	(X3) DATE SURVE COMPLETED		
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	PROVIDER OR SUPPLIER GE HALL FRONT RO	YAL		400	EET ADDRESS, CITY, STATE, ZIP CODE WEST STRASBURG ROAD ONT ROYAL, VA 22630			
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F 659	accordance with eacare. This REQUIREME by: Based on observa interview, family intreview, and clinical determined the factory of the phyresidents in the surface of the phyresident #196 was 8/13/2018 with diagnot limited to: chrodisease (COPD- is nonreversible lung combination of embronchitis). (1)  There was no minital assessment complete of the Nursing Admis 8/13/18 documented and oriented.  The physician orded documented, "O2 ((liters/minute) NC (with two prongs the continuous".	ach resident's written plan of NT is not met as evidenced tions, resident interview, staff erview, facility document record review it was ility staff failed to administer ysicians order for one of 31 evey sample, Residents #196. Iled to ensure a trained staff red oxygen to resident #196 e:  I admitted to the facility on gnosis that included but were nic obstructive pulmonary a general term for chronic, disease that is usually a physema and chronic mum data set (MDS) eted at the time of the survey, sion Assessment dated at that the resident was alert or dated 8/13/2018		659	C.N.A. #1 received one on one in training on the C.N.A. job duties appropriate resident care to be proby a C.N.A.  Identification of Deficient Practices/Corrective Action(s): All other residents receiving phy ordered oxygen may have been potentially affected. The DON, A and/or Unit Managers will conduct 100% review of all resident physodrered oxygen orders to identify residents at risk for not following implementing physician ordered orders. All residents identified at be corrected at time of discovery Incident & Accident form will be completed for each negative find attending physician will be notified each incident.  Systemic Change(s):  The facility policy and procedure following and implementing phy ordered oxygen use has been reveand no revisions are warranted at time. The DON and/or regional reconsultant will inservice all Nurson following the physician order Oxygen orders to include correct and usage schedule. In addition, C.N.A. staff will be inserviced of appropriate job duties to be perfect. N.A. staff to include not adjust removing oxygen or tube feeding connections during resident care.	and the rovided  Sician  ADON  Let a sician by g and/or oxygen trisk will and an eling. The lied of sician riewed this nurse sing staff red thow rate all nurse all nurse sing staff red trior rowed trior rowed the flow rate all nurse sing staff red trior rowed trior rowe		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		TPLE CONSTRUCTION	()	X3) DATE SURVEY COMPLETED
		495301	B. WING _			C 08/23/2018
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F 659	Resident #196 was stated they normally On 08/22/18 at 08:0 was made; again the with oxygen set to 2 asked if she adjuster resident denied doin p.m., a third observe was lying in bed with bedside without a Normal flow meter on the outrned on at a rate of being worn by the redaughter who was not interviewed. Resident #196 bas but didn't put the oxygen asked to measure the resident receinformed Resident #196.  An interview was concretely was then informed from the resident receinformed Resident receinfor	this time, an interview with conducted. Resident #196 y use "2.5" (liters of oxygen). 24 a.m. a second observation be resident was lying in bed 2.5L/min. The resident was ed her own oxygen, the lation was made. The resident her daughter present at IC being worn. The oxygen oxygen concentrator was lot 2-2.5L/min but was not esident. At that time, the levith the resident was level to be different was lot with the resident was level to be different was lot with the resident was level to be different was level to be different was lot with the resident was level to be different was level	F 65	Monitoring: The DON is responsible for main compliance. The DON, ADON, a Unit Manager will perform 3 range rounds weekly to monitor for approxygen use per physician orders monitor for compliance. Any/all findings will be corrected at time discovery and disciplinary action taken as needed. Aggregate finds these reviews will be reported to Quality Assurance Committee que for review, analysis, and  recommendations for change in policy, procedure, and/or practic Completion Date: 10/1/18	and/or dom unit propriate to negative of will be ings of the parterly	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495301	B. WING		20002000	C <b>/23/2018</b>	
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP CO 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORE  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE AI  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 659	oxygen flow meter. and stated 2L. Whe meter was suppose responded, "The beto be at the top of the which staff had wore earlier. LPN #3 rep (CNA) #1. When as adjust oxygen LPN During an interview CNA (Restorative A are allowed to admor put and take oxy CNA#1 answered "if she remove or ac 196, CNA #1 answered "if she remove dwith administration of oxygen, turway, ASM#2 answeresponsibility that we remove oxygen, turway, ASM#2 answeresponsibility that we responsibility that we remove oxygen, turway, ASM#2 answeresponsibility that we responsibility that we respons	LPN #3 read the flow meter en asked how an oxygen flow ed to be read, LPN#3 bettom of the ball is supposed to line." LPN 3# was then asked read with Resident #196 lied certified nursing assistant sked if CNA's can remove or #3 stated, "No".  If on 08/22/18 2:40 p.m. with aid) #1, when asked if CNA's inister oxygen, adjust oxygen igen on or off a resident, yes". When CNA#1 was asked ljust the oxygen for Resident # ered "yes".  p.m., an interview was ininistrative staff member effor of nursing (DON), and LPN irector of nursing. Both were tive aid was a CNA to which is. When asked if a CNA can in it on or off, or adjust it in any ered, "That's the nurse's would be a No."  rescription for a CNA did not mentation regarding the	F 6	59			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NITIMBED		TIPLE CONSTRUCTION		E SURVEY IPLETED
		495301	B. WING	B. WING		C 23/2018
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE
	Potter, 6th edition, treated as a drug. I such as atelectasis drug, the dosage of should be continuous should routinely chowerify the client is reconcentration. The administration also administration."  The administrator amade aware of the p.  No further information.	amental of Nursing, Perry and page 1122, Oxygen should be thas dangerous side effects, or oxygen toxicity. As with any concentration of oxygen usly monitored. The nurse eck the physician's orders to ecciving the prescribed oxygen six rights of medication pertain to oxygen.  ASM #1 and ASM# 2 were above concern 8/22/18 at 6:00 ion was provided prior to exit.  Eary of Medical Terms for the er, 5th edition, Rothenberg and		F684 Corrective Action(s): Resident #11's attending physician w	35	141/18
	applies to all treatn facility residents. B assessment of a rethat residents rece accordance with propractice, the comporare plan, and the This REQUIREME by:	fundamental principle that nent and care provided to ased on the comprehensive esident, the facility must ensure ive treatment and care in rofessional standards of rehensive person-centered		notified that the facility staff failed to follow the physician ordered sliding sadminister schedule. A facility Incide and Accident form was completed for incident.  Identification of Deficient Practices/Corrective Action(s): All other residents receiving physicia ordered sliding scale insulin orders in have been potentially affected. The ADON, and Unit Managers will continue to the ADON and it is all residents with physicial physicians and the same and t	cate  nt  this  an  nay  DON,  duct a  sician	

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	СОМ	E SURVEY PLETED
		495301	B. WING				C 23/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL FRONT ROYAL			400	EET ADDRESS, CITY, STATE, ZIP CODE WEST STRASBURG ROAD ONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	C	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	and clinical record facility staff failed to provided in accorda standards of practic care plan for one or sample, Resident #  The facility staff fail orders for sliding so Resident #11. On (licensed practical units of Novolog insto Resident #11, insprescribed 12 units sugar reading of 34.  The findings included Resident #11 was a 7/21/16 with diagnoral limited to: diabetes depression, anxiety impairment.  The most recent M assessment, a qual assessment references ident as scoring interview for mental was moderately im decisions. The resino assistance to linicativities of daily live.  The comprehensive documented in part Mellitus risk for high predicts her needs	review, it was determined the persure treatment was ance with professional ce, and the comprehensive of 31 residents in the survey in the surv	F6	84	identify resident at risk. Residents identified at risk will be corrected a of discovery and their comprehensi plans of care updated to reflect their resident specific needs. The attendit physicians will be notified of each negative finding and a facility Incic Accident Form will be completed finegative finding.  Systemic Change(s):  The facility policy and procedures been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by 24 Hour Report and documentation medical record /physician orders rethe source document for the develor and monitoring of the provision of which includes, obtaining, transcrif and completing physician orders, medication orders, treatment orders. DON and/or Regional nurse consult will inservice all licensed nursing a the procedure for obtaining, transcrif and completing physician medication treatment orders. To include perfor physician ordered sliding scale instruction and completing physician medication administration orders.  Monitoring:  The DON will be responsible for maintaining compliance. The DON ADON and/or Unit Manager will proceeding plan calendar to monitor for compliance. Any/all negative finding or errors will be corrected at time of discovery and disciplinary action weaken as needed. Aggregate finding these audits will be reported to the Quality Assurance Committee quarfor review, analysis, and	the in the mains pment care, bing tant taff on ibing, on and ming alin	

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		100 300	IPLE CONSTRUCTION  NG	COV	E SURVEY MPLETED
		495301	B. WING _		3 4	/23/2018
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL			10000000	STREET ADDRESS, CITY, STATE, ZIP COI 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	glucose readings." documented in part orders. BS per orde or s/s (signs and sy hypo/hyperglycemia sugars)."  The physician orde "BS (blood sugar) A Novolog SQ (subcu Below 130 = O (uni 131 - 180 = 4 u (uni 181 - 240 = 8 ui 241 - 300 = 1 - ui 301 - 350 = 12 ui 351 - 400 = 16 ui yereater than) 400 (medical doctor)."  The August 2018 M record) documente at 11:30 a.m., the m sugar as "348." The insulin administered blood sugar on 8/4/ the blood sugar as  An interview was co practical nurse) #3, asked if physician of for blood sugars sh stated, "Absolutely.  An interview was co nurse that gave the on 8/23/18 at 10:02 insulin was read to	The "Approaches"  c, "Give medications per  er. Notify MD of changes in BS  mptoms) of  a (too low or too high blood  r dated, 6/7/18, documented,  AC (before) meals w/ (with)  staneous) Sliding Scale:  ts)  ts)  D = 20 u & (and) call MD  IAR (medication administration d the above order. On 8/4/18  urse documented the blood d documented amount of d was "16." The next recorded (18 at 4:30 p.m. documented (174."  Inducted with LPN (licensed on 8/23/18 at 8:22 a.m. When orders for sliding scale insulin ould be followed, LPN #3		recommendations for change in policy, procedure, and/or practice. Completion Date: 10/1/18		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			) DATE SURVEY COMPLETED
		495301	B. WING	and the state of t		C 08/23/2018
NAME OF PROVIDER OR SUPPLIER HERITAGE HALL FRONT ROYAL		8	STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		00/23/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ULD BE	(X5) COMPLETION E DATE
F 684	reading of 348, LP! MAR for August of #6 and her docume units. LPN #6 state asked if that was for LPN #6 stated, "No blood sugar on 8/4, with LPN #6. LPN #6 that. That's a mistal The facility policy, documented in paradministered in a sprescribed7. The medication must of times to verify the right dosage, right of administration be medication, the ind medication will record: a. The date administered. b. The date administered. b. The date administration. d. Tapplicable)g The person administerial In "Fundamentals of Patricia A. Potter at Inc.; Page 419. "To directing medical trobligated to follow believe the orders a clients."	N #6 stated, "12 units." The 2018 was reviewed with LPN entation of administering "16" id, "That was an error." When ollowing the physician's order, o, I made a mistake." The /18 at 4:30 p.m. was shared #6 stated, "I didn't realize I did ike and I am responsible."  Administering Mediations," it, "Medications shall be afe and timely manner, and as individual administering the neck the label THREE (3) right resident, right medication, time, and right method (route) are giving the serequired or indicated for a lividual administering the ord in the resident's medical and time the medication was ne dosage. c. The route of the injection site (if signature and title of the ng the drug."  of Nursing" 6th edition, 2005; and Anne Griffin Perry; Mosby, the physician is responsible for reatment. Nurses are physician's orders unless they are in error or would harm	F 6	84		
	administrator, and	f member (ASM) #1, the ASM #2, the director of e aware of the above concern a.m.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	3	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		495301	B. WING	arounte au ver des	90	3/23/2018
	PROVIDER OR SUPPLIER	/AL		STREET ADDRESS, CITY, STATE, Z 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	IP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO' DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 684 F 695 SS=D	following website: https://dailymed.nln m?setid=cd88e313 d Respiratory/Trache	ge 36 was obtained from the n.nih.gov/dailymed/drugInfo.cf -6193-4413-beff-7d955580060 ostomy Care and Suctioning	F6	95 <b>F</b> 695		10/1/17
	The facility must en needs respiratory of care and tracheal so care, consistent with practice, the comproare plan, the reside and 483.65 of this some This REQUIREMED by:  Based on observation interview, family interview, and clinical determined the factorygen per the phyresidents in the surfand Resident #6.  1. The facility staff per the physician order  The findings including the findings including the physician order.	and tracheal suctioning. Issure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of rehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced tions, resident interview, staff erview, facility document record review it was lity staff failed to administer sicians order for two of 31 vey sample, Residents #196  failed to administer oxygen, rder, for Resident #196.  failed to administer oxygen per , for Resident #6.		Corrective Action(s): Resident #196 & #6's atte was notified that residents not receive oxygen at the as ordered by the physicia Incident & Accident form completed for this incident  Identification of Deficient Corrective Action(s): All residents receiving oxy have potentially been affer review of all resident's ox be conducted by the DON Unit Manager to identify the Residents found to be at ricorrected at the time of dis Incident & Accident form for each item discovered.  Systemic Change(s): The facility policy and pro Oxygen administration has and no changes were warn time. All licensed nursing inserviced on the facility p procedure for accurate oxy administration and monito physician order. Inservices the delivery of oxygen per and the monitoring oxygen throughout the shift.	s#196 & #6 did correct flow rate in. A facility has been it.  It Practices & ygen therapy may cted. A 100% ygen orders will , ADON and/or residents at risk. isk will be scovery. A facility will be completed  ocedure for s been reviewed anted at this staff will be colicy and ygen ring per s will include physician order	

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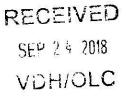
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8 8	PLE CONSTRUCTION IG	COV	TE SURVEY MPLETED
		495301	B. WING _			C /23/2018
	PROVIDER OR SUPPLIER SE HALL FRONT RO	YAL		STREET ADDRESS, CITY, STATE, ZIP COD 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 695	disease (COPD- is nonreversible lung combination of embronchitis). (1)  There was no mini assessment comp The Nursing Admis 8/13/18, document oriented.  The physician orde "O2 (oxygen) at 2L cannula - a plastic insert in the nose)  On 08/21/18 at 03: observed lying in ban oxygen concenset to 2.5L/min. A'Resident #196 was stated they normal On 08/22/18 at 08: was made; again twith oxygen set to asked if she adjusted the index of the deside without a flow meter on the daughter who was interviewed. Resider "staff had took off"	nic obstructive pulmonary a general term for chronic, disease that is usually a physema and chronic  mum data set (MDS) leted by the time of the survey. ssion Assessment dated red the resident was alert and  er dated 8/13/2018 documented /min (liters/minute) NC (nasal tube with two prongs that continuous".  45 p.m., Resident #196 was red wearing a NC connected to trator with the oxygen flow rate this time, an interview with s conducted. Resident #196 ly use "2.5" (liters of oxygen). 104 a.m. a second observation he resident was lying in bed 2.5L/min. The resident was ted her own oxygen, the ing this. On 08/22/18 2:16 vation was made. The resident th her daughter present at NC being worn. The oxygen oxygen concentrator was of 2-2.5L/min but was not resident. At that time, the with the resident was ent #196's daughter stated the oxygen to transfer her ack to bed thirty minutes prior		Monitoring: The DON is responsible for mair compliance. The DON, ADON a Unit manager will perform daily all residents using oxygen to mo compliance. All negative finding corrected at time of discovery ar appropriate disciplinary action will reported to the Quality Assi Committee for review, analysis, recommendations for change in policy, procedure, and/or practi Completion Date: 10/1/18	audits of audits of nitor for s will be id vill be idings irance and facility	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED	
		495301	B. WING			C 08/23/2018	
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 695	evidence document Resident #196.  An interview was concerned Nurse (LP When asked what on Resident #196, LP #3 was then asked oxygen flow meter observed wearing to but the oxygen concerned the flow measked how an oxygen to be read, LPN #3 the ball is supposed LPN #3 then placed Observation of Resident #100 per placed of the flow resident #100 per placed flow resident flow	plan dated 8/13/2018, failed to tation of the use of oxygen for conducted with Licensed (N) #3 on 8/22/18 at 2:20 p.m. oxygen had been ordered for N #3 responded 2L/min. LPN to read Resident #196's [Resident #196 was not the nasal cannula at this time, centrator was running]. LPN eter and stated 2L. When the flow meter was supposed responded, "The bottom of the top of the line". If O2 via NC on Resident #196. ident #196 oxygen flow meter the was set at 2.5 L/min. and	F 69	20 10 100000000000000000000000000000000			
	director of nursing ( assistant director of the oxygen flow me stated, "The line sh the ball."  According to the Re manual page 6 for the was at Resident #1						

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495301	B. WING		OR	C /23/2018
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP OF 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		12072410
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 695	marking the specific The Medication Add 2018, for Resident was being administ According to the farpolicy "8. Place appresident10. Adjusts that it is comfort proper flow of oxyg According to Funda Potter, 6th edition, treated as a drug. I such as atelectasis drug, the dosage of should be continuous should routinely chaverify the client is reconcentration. The administration also administration."  The administrator Adirector of nursing concern 8/22/18 at No further information. Barron's Dictional Non-Medical Read Chapman, page 12	ministration Record for August #196 documented that oxygen ered at 2L/min.  cilities oxygen administration propriate oxygen device on the st the oxygen delivery device able for the resident and the en is being administered.  Amental of Nursing, Perry and page 1122, Oxygen should be thas dangerous side effects, or oxygen toxicity. As with any reconcentration of oxygen usly monitored. The nurse eck the physician's orders to ecciving the prescribed oxygen six rights of medication pertain to oxygen  ASM #1 and ASM# 2, the were made aware of the above 05:10 p.m.  ion was provided prior to exit.  ary of Medical Terms for the er, 5th edition, Rothenberg and	F 6	95		
	with diagnoses, wh	for Resident #6.  dmitted to the facility 4/20/16 ich included but were not lisorder, arthritis, depression,				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		495301	B. WING		08	C /23/2018
	PROVIDER OR SUPPLIER  GE HALL FRONT RO	YAL		STREET ADDRESS, CITY, STATE, ZIP COL 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		CONTRACTOR
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 695	diabetes, high blood. The most recent M assessment, an an assessment refered resident as scoring interview for mental resident was cognit decisions. The resident was cognit decisions. The resident was sistance was sistance of the second of	d pressure, and dementia.  DS (minimum data set) nual assessment, with an noce date of 5/28/18, coded the a "15" on the BIMS (brief I status) score, indicating the tively intact to make daily dent was coded as requiring of her activities of daily living sich she was independent after was provided. In Section O - s, Procedures, and Programs, oded as having used oxygen ays of the look back period.  The definition of the first was in bed with her hasal cannula (plastic tube with ert into the nose), connected entrator. The oxygen et at 4L/min (liters/minute).  The resident was still in ygen on via the nasal cannula ygen concentrator. The oxygen concentrator. The oxygen concentrator. The oxygen concentrator that the oxygen flow meter LPN (licensed practical nurse) that the oxygen flow meter LPN #3 stated he did not have cribed for 4 liters. He stated oposed to be on 2 liters. LPN cal record and verified the on 2L/min per the physician	F6	95		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE S COMPL	
	65 (9827) 65	495301	B. WING _			C 08/23	/2018
	PROVIDER OR SUPPLIER	/AL	1	STREET ADDRESS, CITY, STATE, ZIP CO 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE C	(X5) COMPLETION DATE
F 695	The physician orde "O2 (oxygen) @ (at nasal cannula at HS per resident reques (nasal cannula) QA  The August 2018 "The August 2018 "The August 2018 "The TAR doctorder. The TAR doctorder. There was no documented in part SOB (shortness of of COPD (chronic of general term for odisease that is usual emphysema and chemphysema and ch	r dated, 8/7/18, documented, ) 2L/m (liters per minute) via 6 (hours of sleep - bedtime) t. Remove O2 at 2L/min NC M (every morning)."  Treatment Administration umented the above physician cumented the administration of vening for each evening in  mented nurse's notes for e care plan dated, 5/30/18, , "Problem/Need: At risk for breath) due to DX (diagnosis) bistructive pulmonary disease hronic, nonreversible lung ally a combination of ironic bronchitis) (1)." The mented in part, "O2 as  Oxygen Administration" , "Purpose: The purpose of provide guidelines for safe onSteps in Procedure: 8. Unless otherwise ordered, gen at the rate of 2 to 3 liters  member (ASM) #1, the #2, the director of nursing,	F 6	95			
	ASM #3, the region (licensed practical r	al nurse consultant, LPN nurse) #1, the assistant and ASM #5. the administrator					

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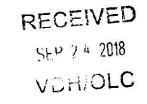
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	30 mod 30 990mm	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
70		495301	B. WING _		C <b>08/23/2018</b>
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 695 F 757 SS=D	in training, were ma concern on 8/22/18 No further informat Drug Regimen is F	ade aware of the above B at 6:00 p.m. ion was provided prior to exit. ree from Unnecessary Drugs	F 69	57 <b>F75</b> 7	191/18
	Each resident's dru unnecessary drugs drug when used- §483.45(d)(1) In ex duplicate drug there			Corrective Action(s): Resident #11's attending physician has been notified that the facility administe an incorrect dose of insulin when performing a sliding scale blood sugar check per physician order. A facility Medication error form was completed each incident.  Identification of Deficient Practice(s	for
	§483.45(d)(3) With	excessive duration; or out adequate monitoring; or out adequate indications for its		and Corrective Action(s): All other residents receiving Physician ordered Insulin may have potentially be affected. A 100% review of all resident with insulin orders will be conducted DON and/or designee to identify resident risk. All residents identified at risk.	nts by
		e presence of adverse ch indicate the dose should be inued; or		be corrected at time of discovery and appropriate disciplinary action taken. Incident and Accident form will be completed for each negative finding.	
	stated in paragraph section. This REQUIREME! by: Based on staff inte and clinical record facility staff failed to unnecessary medic in the survey samp	combinations of the reasons as (d)(1) through (5) of this  NT is not met as evidenced erview, facility document review review, it was determined the censure a resident was free of cations for one of 31 residents le, Resident #11.		Systemic Change(s):  The facility policy and procedure has been reviewed and no changes are warranted at this time. All Licensed s will be inserviced on the facility police and procedure by the DON regarding administration of medications per physician orders to include the proper administration of insulin to include administering sliding scale insulin as ordered by the physician and following blood sugar parameters as ordered by physician.	staff cy the ar

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	124100000000000000000000000000000000000		LE CONSTRUCTION		E SURVEY PLETED
		495301	B. WING		254	02/2018	
NAMEOE	PROVIDER OR SUPPLIER	173001			STREET ADDRESS, CITY, STATE, ZIP CODE	( 08/2	23/2018
INAME OF I	HOVIDEN ON SOIT EIEN				400 WEST STRASBURG ROAD		
HERITAG	E HALL FRONT RO	YAL					
			1		FRONT ROYAL, VA 22630		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 757	Continued From pa	ge 43	F7	757			
9	prescribed by the p reading of 348 on 8				Monitoring: The Director of Nursing is responsible for maintaining compliance. The DON and/designee will do weekly MAR audits to monitor for compliance. Any negative	or	
	The findings includ	e: admitted to the facility on			findings will be addressed at the time of discovery and appropriate disciplinary action taken. Detailed findings of these		
	7/21/16 with diagno	oses that included but were not high blood pressure,			results will be reported to the Quality Assurance Committee for review,		
		disorder and mild cognitive			analysis, and recommendations for change in facility policy, procedure, and/or practice.		
	assessment, a qua assessment references resident as scoring interview for menta was moderately im decisions. The resi	DS (minimum data set) rterly assessment, with an noce date of 6/20/18, coded the a "12" on the BIMS (brief I status) score, indicating she paired to make cognitive daily dent was coded as requiring nited assistance for her ing.			Completion Date: 10/1/18		
T. Carlo	"BS (blood sugar) /	or dated, 6/7/18, documented, AC (before) meals w/ (with) citing insulin (1)) SQ					
	(subcutaneous) Sfi Below 130 = O (uni 131 - 180 = 4 u (uni 181 - 240 = 8 u	ding Scale: its)					
	241 - 300 = 1- u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 40 (medical doctor)."	0 = 20 u & (and) call MD					
	record) documente at 11:30 a.m., the r	MAR (medication administration of the above order. On 8/4/18 nurse documented the blood e documented amount of					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100000000000000000000000000000000000000	TIPLE CONSTRUCTION NG		re survey MPLETED
		495301	B. WING		08	C /23/2018
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP COL 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLÉTION DATE
F 757	blood sugar on 8/4, the blood sugar as  The comprehensive documented in part Mellitus risk for hig predicts her needs thinks she is feeing glucose readings." documented in part orders. BS per orders. BS per orders. BS per orders asked if physician of physician of physician of physician of blood sugars sheated, "Absolutely.  An interview was conurse that gave the on 8/23/18 at 10:02 insulin was read to amount of insulin president have received in the president have received in the physician of the state asked if that was for LPN #6 stated, "No blood sugar on 8/4 with LPN #6. LPN in that. That's a mistalent in the president has a mistalent in the physician of the stated, "No blood sugar on 8/4 with LPN #6. LPN in that. That's a mistalent in the part of the physician of the physic	d was "16." The next recorded (18 at 4:30 p.m. documented "74."  e care plan dated, 5/30/18, t, "Problem/Need: Diabetes h and lows of BS. Resident and intake based on how she to vs (versus) actual number of The "Approaches" t, "Give medications per er. Notify MD of changes in BS (mptoms) of a (too low or too high blood conducted with LPN (licensed on 8/23/18 at 8:22 a.m. When orders for sliding scale insuling toold be followed, LPN #3	F 7	57		

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Event ID: 6RF911

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PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	AND THE STATE OF T	E CONSTRUCTION		TE SURVEY MPLETED
		495301	B. WING		08	C /23/2018
	PROVIDER OR SUPPLIER	YAL	4	TREET ADDRESS, CITY, STATE, ZIP COD 00 WEST STRASBURG ROAD RONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 757	administered in a sprescribed7. The medication must of times to verify the right dosage, right of administration be medication20. As medication, the individual medication will record: a. The date administered. b. The administration. d. Tapplicable)g The person administerion. According to "Funce Edition, 2009: by P"Medication Administerion administration administration, and	it, "Medications shall be afe and timely manner, and as individual administering the neck the label THREE (3) light resident, right medication, time, and right method (route) efore giving the required or indicated for a lividual administering the ord in the resident's medical and time the medication was ne dosage. c. The route of the injection site (if signature and title of the neg the drug."  I amentals of Nursing", Seventh erry and Potter Chapter 35 at standards, such as the association's Nursing: Scope dursing Practice (2004) apply edication administration. To a errors, follow the six rights estration consistently every time dications. Many medication d, in some way, to an albering to the six rights of estration include the following: 1. on, 2. The right dose, 3. The right route, 5. The right time, becumentation."  If member (ASM) #1, the ASM #2, the director of e aware of the above concern				

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Event ID: 6RF911

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	g 10 - 40	LE CONSTRUCTION		TE SURVEY MPLETED
		495301	B. WING		30	C /23/2018
	PROVIDER OR SUPPLIER	YAL	STREET ADDRESS, CITY, STATE, 2 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	following website: https://dailymed.nlr m?setid=cd88e313 d	n was obtained from the n.nih.gov/dailymed/drugInfo.cf s-6193-4413-beff-7d955580060	F 757			3/1/6
F 760 SS=D	CFR(s): 483.45(f)(2) The facility must er §483.45(f)(2) Reside medication errors. This REQUIREMED by: Based on staff interest and clinical record facility staff failed to a significant medical residents in the sure and clinical residents in the sure The facility staff and Novolog insulin (as Resident #11, than documented for a build The findings included Resident #11 was a 7/21/16 with diagnoral limited to: diabetes depression, anxiety impairment.  The most recent Massessment, a qual assessment references ident as scoring interview for mental	nsure that its- dents are free of any significant  NT is not met as evidenced  erview, facility document review review, it was determined the c ensure a resident was free of ation error for one of 31 rvey sample, Resident #11.  ministered four more units of short acting insulin (1)) to what the physician's orders blood sugar reading of 348.	F 760	Corrective Action(s): Resident #11's attending physicial been notified that the facility adm 4 more units of insulin than was a per the sliding scale insulin order involved in administrating the indinsulin dose has received one-oninservice training from the DON administration of physician order medications. A facility Medication form was completed for each incompleted for each negation for each incompleted for each negation for each incompleted for each incompleted facility policy and procedure by regarding the administration of medications per physician orde include the proper administration sliding scale insulin per physician orde include the proper administration in the source of the proper administration in the proper administration in the proper administration in the proper administration of medications per physician orde include the proper administration in the prope	inistered ordered LPN #6 correct LPN #6 cor	

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Event ID: 6RF911

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SEP 2 4 2018 VDH/OLC

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED	
		495301			08	C 08/23/2018
	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIF 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 760	decisions. The resino assistance to linactivities of daily live. The physician order "BS (blood sugar) in Novolog SQ (subcombelow 130 = 0 (und 131 - 180 = 4 u (und 181 - 240 = 8 udo 181 - 240 = 8 udo 181 - 240 = 10 udo 181 - 240 udo 181 - 240 udo 181 - 240 udo 181 - 240 udo 181 ud	dent was coded as requiring nited assistance for her ing.  If dated, 6/7/18, documented, AC (before) meals w/ (with) utaneous) Sliding Scale: its)  If a comparison of the above order. On 8/4/18 nurse documented the blood e documented amount of d was "16." The next recorded "74."  If a care plan dated, 5/30/18, t, "Problem/Need: Diabetes h and lows of BS. Resident and intake based on how she as vs (versus) actual number of The "Approaches" t, "Give medications per er. Notify MD of changes in BS		Monitoring: The Director of Nursing is a maintaining compliance. The designee will perform 2 ran Medication Pass audits to a compliance. Any negative feeddressed at the time of discappropriate disciplinary act Detailed findings of these responsed to the Quality Assa Committee for review, analyrecommendations for change policy, procedure, and/or pictory Completion Date: 10/1/18	ne DON and/or dom weekly conitor for indings will be covery and ion taken. esults will be urance ysis, and ge in facility ractice.	

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Event ID: 6RF911

Facility ID: VA0101

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		627 20	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495301	B. WING		08	C 08/23/2018	
	PROVIDER OR SUPPLIER		82	STREET ADDRESS, CITY, STATE, ZIP 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE	
F 760	for blood sugars sistated, "Absolutely An interview was onurse that gave the on 8/23/18 at 10:00 insulin was read to amount of insulin president have recereading of 348, LP MAR for August of #6 and her documunits. LPN #6 stated asked if that was for LPN #6 stated, "Not blood sugar on 8/4 with LPN #6. LPN that. That's a mistated in paradministered in a sprescribed7. The medication must of times to verify the right dosage, right of administration be medication, the incomedication will received	nould be followed, LPN #3 ."  conducted with LPN #6, the e insulin on 8/4/18 at 1:30 a.m. 2 a.m. The above order for LPN #6. When asked what ber the order, should the ived, for the blood sugar N #6 stated, "12 units." The 2018 was reviewed with LPN entation of administering "16" ed, "That was an error." When following the physician's order, fo, I made a mistake." The /18 at 4:30 p.m. was shared #6 stated, "I didn't realize I did ake and I am responsible."  "Administering Mediations," tt, "Medications shall be safe and timely manner, and as individual administering the heck the label THREE (3) right resident, right medication, time, and right method (route) efore giving the s required or indicated for a lividual administering the ord in the resident's medical e and time the medication was the dosage. c. The route of					
	applicable)g The person administeri According to "Fund Edition, 2009: by P	The injection site (if signature and title of the ng the drug."  damentals of Nursing", Seventherry and Potter Chapter 35 istration" Chapter 35, pg 707	n j				

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Event ID: 6RF911

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SEP 2 4 2018
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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495301	B. WING _			23/2018	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	1 00.	20,2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 760	American Nurses and Standards of to the activity of m prevent medication medication admin you administer me errors can be linked inconsistency in a medication admin medication admin medication admin The right medication administration administration administrative standards in the action of the proposed of the pro	nal standards, such as the Association's Nursing: Scope Nursing Practice (2004) apply redication administration. To n errors, follow the six rights istration consistently every time edications. Many medication ed, in some way, to an dhering to the six rights of istration. The six rights of istration include the following: 1. ion, 2. The right dose, 3. The right route, 5. The right time, ocumentation."  a rapid-acting human insuling wer blood glucose.""5.3 he most common adverse therapies, including re hypoglycemia can cause do to unconsciousness may be cause death." "10 Excess insulin administration lycemia and hypokalemia. Mild plycemia usually can be treated Adjustments in drug dosage, exercise may be needed. More with coma, seizure, or ment may be treated with cutaneous glucose. Sustained we and observation may be se hypoglycemia may recur after ecovery. Hypokalemia must be	F 76				
		de aware of the above concern					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING			(X3) DATE SURVEY COMPLETED C	
		495301	B. WING	4-4	08/23/2018	
	PROVIDER OR SUPPLIER	YAL	400	REET ADDRESS, CITY, STATE, ZIP CODE D WEST STRASBURG ROAD RONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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	(X5) COMPLETION DATE
F 760	following website: https://dailymed.nlr m?setid=cd88e313 d	a.m. n was obtained from the m.nih.gov/dailymed/drugInfo.cf 8-6193-4413-beff-7d955580060	F 760			10/1/18
F 842 SS=D	webiste:https://dail glnfo.cfm?setid=3a 2be56fc5 Resident Records CFR(s): 483.20(f)(s) §483.20(f)(5) Resid (i) A facility may not resident-identifiable (ii) The facility may resident-identifiable accordance with a agrees not to use of except to the exter to do so. §483.70(i) Medical §483.70(i)(1) In ac professional stand must maintain meditat are- (i) Complete; (ii) Accurately docu (iii) Readily access (iv) Systematically §483.70(i)(2) The all information con	dent-identifiable information. It release information that is the to the public. It release information that is the to an agent only in contract under which the agent or disclose the information the facility itself is permitted  records. Cordance with accepted ards and practices, the facility dical records on each resident  umented; sible; and	F 842	Corrective Action(s): Resident #11 attending physicians been notified that the facility failed notify the physician of an elevated sugar per physician order and did accurately document blood sugar r in the Medication administration red A facility Incident & Accident for been completed for this incident.  Identification of Deficient Practic Corrective Action(s): All other residents may have poten been affected. A 100% review of a resident Medical Records will be conducted by the DON, ADON, ar designee to identify residents at ris negative findings will be clarified a correct as applicable at time of disc A facility Incident & Accident form be completed for each negative find Systemic Change(s): The facility policy and procedure here reviewed and no changes are warranted at this time. All licensed nursing staff, Social Services direct Activity Director and dietary mana	d to l blood not results record. m has  ces & ntially all and or covery. m will ding.	

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		405204	B. WING				90
NAME OF I	PROVIDER OF SUPPLIER	495301	B. WING		TOTAL ADDRESS OF ATATE TO SORE	08/2	23/2018
	GE HALL FRONT RO	<b>/AL</b>		40	REET ADDRESS, CITY, STATE, ZIP CODE 10 WEST STRASBURG ROAD RONT ROYAL, VA 22630		
(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 APPROP	BE	(X5) COMPLETION DATE
F 842	(ii) Required by Law (iii) For treatment, poperations, as perm with 45 CFR 164.50 (iv) For public healt neglect, or domesti activities, judicial ar law enforcement pupurposes, research medical examiners, a serious threat to by and in compliance §483.70(i)(3) The farecord information aunauthorized use.  §483.70(i)(4) Medic for- (i) The period of tim (ii) Five years from there is no requiren (iii) For a minor, 3 y legal age under State §483.70(i)(5) The minor (ii) Sufficient information in the comprehendation of the results of a and resident review determinations controlled;	en release is- or their resident re permitted by applicable law; v; vayment, or health care nitted by and in compliance 06; h activities, reporting of abuse, c violence, health oversight nd administrative proceedings, irposes, organ donation purposes, or to coroners, funeral directors, and to avert nealth or safety as permitted be with 45 CFR 164.512.  acility must safeguard medical against loss, destruction, or  all records must be retained the required by State law; or the date of discharge when ment in State law; or the date of discharge the date of discharg	F	342	will be inserviced by the Regional Nurs Consultant or DON on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include Physician Orders, MAR's, TAR's and department notes according to the acceptable professional standards and practices.  Monitoring:  The DON and Medical Records director are responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audicoinciding with the Care Plan scheduler 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: 10/1/18	al ts to ee at	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		16	PLE CONSTRUCTION  G		COMPLETED	
		495301	B. WING _		08	C /23/2018
	PROVIDER OR SUPPLIER GE HALL FRONT RO			STREET ADDRESS, CITY, STATE, ZIP CO 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		,23,23,13
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 842	(vi) Laboratory, raiservices reports at This REQUIREMED by: Based on staff int and clinical record facility staff failed accurate clinical rethe survey sample.  A. The facility staff notification of the sugar for Resident.  B. The facility staff blood sugar reading.  The findings included the survey sample and the survey sample.  A. Resident #11 w 7/21/16 with diagnostic limited to: diabeted depression, anxiet impairment.  The most recent in assessment references assessment references assessment references assessment interview for ment was moderately in decisions. The resident as scoring interview for daily limited to: diabeted depressions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for daily limited to: diabeted depressions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for daily limited to: diabeted depressions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for ment was moderately in decisions. The resident as scoring interview for ment was moderately in decisions.	diology and other diagnostic is required under §483.50. ENT is not met as evidenced review, facility document review review, it was determined the to maintain a complete and ecord for one of 31 residents in a, Resident #11.  If failed to document the physician for an elevated blood t #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document the actual rigs for Resident #11.  If failed to document #11.  If failed to document #12.  If failed to document #12.  If failed to document #13.  If failed to document the actual right rig	t .			

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION IG	CON	(X3) DATE SURVEY COMPLETED C	
		495301	B. WING _			/23/2018
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP C 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		20.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 842	Below 130 = O (u 131 - 180 = 4 u (u 181 - 240 = 8 u 241 - 300 = 1 - u 301 - 350 = 12 u 351 - 400 = 16 u > (greater than) 4 (medical doctor)."  The June 2018 M (MAR) documented On 6/26/18 at 4:3 the blood sugar a notes and the nur documentation of (registered nurse)  The comprehensi documented in pa Mellitus risk for hi predicts her need thinks she is feeir glucose readings documented in pa orders. BS per or or s/s (signs and hypo/hyperglycen sugars)."  An interview was 8/22/18 at 6:46 p. the above order for asked if she notifi sugar, RN #2 stat her (the doctor's) further stated, "I'v time. If it's not doc	nits) Inits)  00 = 20 u & (and) call MD	F 84			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILL	ing		С	
		495301	B. WING		100	23/2018	
	PROVIDER OR SUPPLIEF		5	STREET ADDRESS, CITY, STATE, ZIP ( 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	#2 was asked to produce the normal decommentation be staff member (AS 8/23/18 at 8:10 a.motes were review they had found do in the doctor's constated they had no stated, "If it's not constated they had not stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated," No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated," No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated," No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated," No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated," No, Ma'am they are coming to document is part of stated, "No, Ma'am they are coming to document is part of stated," N	provide evidence that she potification in the doctor's pok.  conducted with administrative M) #2, the director of nursing on m. The blood sugar and nurse's red with ASM #2. When asked if cumentation of the notification numerication book, ASM #2 of found it. ASM #2 further documented it's not done."  conducted with LPN (licensed on 8/23/18 at 8:20 a.m. When can ordered sliding scale dias written, LPN #3 stated, in asked if the blood sugar is and you notify the doctor, where documented, LPN #3 stated, "In "  a.m. presented a document of Resident #11 that was printed on m. The attending physician LPN #1 stated, "We print these 1:00 p.m. to 7:00 a.m.) shift for urse practitioners for the days of the facility." When asked if this of the clinical record, LPN #1 m."		342			
	documented in pa resident, progress any changes in the functional or psychocumented in the	"Charting and Documentation" or, "All services provided to the toward the care plan goals, or e resident's medical, physical, hosocial condition, shall be e resident's medical record. The could facilitate communication					

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	STATE OF THE PARTY	TIPLE CONSTRUCTION		E SURVEY
		495301	B. WING	··-		C /23/2018
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		23/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 842	between the interdiresident's condition following information resident medical reobservations. b. Me Treatments or servithe resident's cond accidents involving toward or changes objectives."  The following quota Fundamentals of N 237): "The client redocument of the clireceivedBecause team members car assessments or intivers after the fact documentation at the care may have documentation must documentation must administrative staff administrator, and nursing, were made on 8/23/18 at 9:50  (1) This information following website: https://dailymed.nlm.grsetid=cd88e313 d	and response to care2. The and response to care2. The in is to be documented in the cord: a. Objective edications administered. c. ices performed. d. Changes in ition. e. Events, incidents or the resident. f. Progress in the care plan goals and ation is found in Lippincott's ursing 5th edition (2007, page cord serves as a legal ent's health status and care enurses and other healthcare mot remember specific erventions involving a client accurate and complete the time of care is essential. The been excellent, but the st prove it."  I member (ASM) #1, the ASM #2, the director of aware of the above concern a.m.  In was obtained from the m.nih.gov/dailymed/drugInfo.cf 1-6193-4413-beff-7d955580060	F8	142		
	blood sugar reading	gs for Resident #11.  R documented the order for the				

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Event ID: 6RF911

Facility ID: VA0101

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HERITAGE HALL FRONT ROYAL  HERITAGE HALL FRONT ROYAL  400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY)  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE TAG DEFICIENCY)	(X5) COMPLETION DATE
F 842  Continued From page 56  sliding scale insulin above. On 7/7/18, 7/8/18 and 7/22/18 at 4:30 p.m. there was no documented blood sugar reading. RN # 1 completed all three dates.  The July 2018 MAR notes documented the following on each of the above dates: "scheduled for 4:30 p.m. bs (blood sugar) < (less than) 130."  Review of the "Vital Signs" section of the electronic record failed to evidence documentation of the blood sugar readings on the above dates and times.  Review of the nurse's notes for the above dates failed to evidence documentation of the blood sugar readings.  An interview was conducted with RN #1 on 8/22/18 at 6:25 p.m. The above MAR was reviewed with RN #1. Uhen asked how the blood sugar reading numbers are entered into the system, RN #1 stated, "A box pops up and you put in the reading." When asked if the actual number for the blood sugar reading should be included in the MAR, RN #1 stated, "I don't know why it isn't there."  An interview was conducted with administrative staff member (ASM) #2, the director of nursing on 8/23/18 at 8:10 a.m. The blood sugar and nurse's notes were reviewed with ASM #2. When asked if they had found documentation of the physician notification in the doctor's communication book, ASM #2 stated they had not found it. ASM #2 further stated, "If it's not documented it's not done."	

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PRINTED: 09/04/2018 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL  SUMMARY STATEMENT OF DEPOSENCES (EACH DESIGNEY WITH REGULATORY OR LSC IDENTIFYING INFORMATION)  FRONT ROYAL, VA 22830  F 842  Continued From page 57 8/23/18 at 8:20 a.m. When asked where the blood sugar readings are documented, LPN #3 stated, "1s probably not in the bood sugar as less than 130, LPN #3 stated, "1s probably not in the bood sugar as less than 130, LPN #3 stated, "1s probably not in the bood sugar results."  Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9/30 a.m.  F 880  Infection Prevention & Control  CFR(s): 433.80(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, santary and comfortable environment and to help prevent the development and transmission of communicable diseases and infection prevention and control program.  F 848.80(a) Infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program.  The facility must establish an infection prevention and control program designed to provide a safe, santary and comfortable diseases and infections.		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CO. AND CO. AND CO. AND CO. AND CO.	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STABLET ADDRESS, CITY, STATE, ZIP CODE			495301	B. WING			
FREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 842  Continued From page 57  8/23/18 at 8:20 a.m. When asked where the blood sugar readings are documented, LPN #3 stated, "A box comes up and you put it there. It then populates to the blood sugar section in the vital signs." When asked if a nurse should document the blood sugar as less than 130, LPN #3 stated, "It's probably not in the best interest to do that."  The facility policy, "Obtaining a Finger stick Glucose Level" documented in part, "DocumentationThe person performing this procedure should record the following information in the resident's medical record:6. The blood sugar results."  Administrative staff member (ASM) #1, the administrative staff member (asM) #1, t				4	00 WEST STRASBURG ROAD		
8/23/18 at 8:20 a.m. When asked where the blood sugar readings are documented, LPN #3 stated, "A box comes up and you put it there. It then populates to the blood sugar section in the vital signs." When asked if a nurse should document the blood sugar as less than 130, LPN #3 stated, "It's probably not in the best interest to do that."  The facility policy, 'Obtaining a Finger stick Glucose Level" documented in part, "DocumentationThe person performing this procedure should record the following information in the resident's medical record6. The blood sugar results."  Administrative staff member (ASM) #1, the administrator, and ASM #2, the director of nursing, were made aware of the above concern on 8/23/18 at 9:50 a.m.  F 880	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	D BE COMPLETION	
a minimum, the following elements:  & Accident form has been completed for each of this incident. RN#1 has received one on one inservice training on proper medication administration by the DON.	F 880	8/23/18 at 8:20 a.m blood sugar readin stated, "A box committen populates to the vital signs." When document the blood stated, "It's profided that."  The facility policy, Glucose Level do "Documentation" procedure should in the resident's managar results."  Administrative staff administrator, and nursing, were mad on 8/23/18 at 9:50 Infection Prevention CFR(s): 483.80(a) Infection prevention designed to provide comfortable environd development and the diseases and infection program.  The facility must estand control program and control program a minimum, the following states are states and control program a minimum, the following states are states and control program a minimum, the following states are states and control program a minimum, the following states are states as a state and control program a minimum, the following states are states as a state and control program a minimum, the following states are states as a state and control program a minimum, the following states are states as a state and control program a minimum, the following states are states as a state and control program and control program a minimum, the following states are states as a state and control program at the states are states as a state and control program and control program a minimum at the states are states as a states and control program and c	m. When asked where the ags are documented, LPN #3 are up and you put it there. It the blood sugar section in the asked if a nurse should d sugar as less than 130, LPN pably not in the best interest to broadly not in part, The person performing this record the following information bedical record:6. The blood broadly not interest in the blood broadly not interest in a same as a same and maintain and and control program are a safe, sanitary and nament and to help prevent the ransmission of communicable tions.  In prevention and control broadlish an infection prevention in (IPCP) that must include, at lowing elements:		F880 Corrective Action(s): The attending physician for Resident #3 was notified that RN#2 touched the insi of the resident's medication cup with he bare fingers prior to medication administration. A facility Incident & Accident form has been completed for each of this incident. RN#2 has receive one on one inservice training on proper medication administration by the DON.  The attending physician for Residents #198 & #21 was notified that RN#1 touched the inside of the resident's medication cups with her bare fingers prior to administration. A facility Incid & Accident form has been completed feach of this incident. RN#1 has receive one on one inservice training on proper	ent	

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Event ID:6RF911

Facility ID: VA0101

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	20 100000000000000000000000000000000000	TIPLE CONSTRUCTION	COM	E SURVEY MPLETED
		495301	B. WING		1	/23/2018
	PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CO 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 880	reporting, investig and communicable staff, volunteers, we providing services arrangement base conducted accord accepted national §483.80(a)(2) Write procedures for the but are not limited (i) A system of surpossible communinfections before the persons in the faction (ii) When and to we communicable distreported; (iii) Standard and to be followed to persons in the faction (iv) When and how resident; including (A) The type and of depending upon the involved, and (B) A requirement least restrictive position of the circumstances. (v) The circumstances (v) The circumstances (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (vi) The hand hygical by staff involved in §483.80(a)(4) A systems (viii) The hand hygical by staff involved in §483.80(a)(4) A systems (viiii) The hand hygical by staff involved in §483.80(a)(4) A systems (viiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ating, and controlling infections e diseases for all residents, visitors, and other individuals under a contractual ed upon the facility assessmenting to §483.70(e) and following standards;  tten standards, policies, and e program, which must include, to:  veillance designed to identify icable diseases or hey can spread to other	F8	The attending physician for res was notified that the facility farensure contact precautions wer implemented when caring for #96. CNA #1 has been inservice DON on the proper contact iso procedure to be utilized when residents on isolation precaution Incident & Accident form was for each incident.  Identification of Deficient Prand Corrective Action(s): All residents may have the potential affected by improper infection medication pass techniques. The and/or Unit Manager will concentrate to observe proper infection practices and proper medication administration procedures. The DON, ADON and/or Unit will conduct audits on resident isolation to observe proper infection practices, proper PPE hand washing during resident negative findings will be addressed in medication administration procedure form will be completed in the facility Infection Control medication administration pol procedure has been reviewed a changes are warranted at this to DON and/or Regional Nurse (will inservice all licensed staff proper medication administration administrat	iled to re resident ced by the clation assisting ons. An completed ractice(s) rential to be control and the DON duct icensed on control on the Manager ts on rection use and care. Any essed action sident and ted for each  policy and and no time. The Consultant f on the	

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Event ID: 6RF911

Facility ID: VA0101

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G	CON	(X3) DATE SURVEY COMPLETED	
		495301	B. WING _		I .	C <b>/23/2018</b>	
250 Annie 2010 - College Annie 2004 - 200	PROVIDER OR SUPPLIER	YAL		STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		20,20,0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	transport linens so infection.  §483.80(f) Annual of The facility will condidered update the This REQUIREMENT by: Based on observation record review, and was determined the follow infection conseven residents in observation, Resident #96.  1. The facility staff of the cup for Resident #36 contamination during 2. The facility staff of the cups for Resident #36 contamination during 3. The facility staff ordered contact prefered c	aken by the facility.  Indie, store, process, and as to prevent the spread of eview.  Iduct an annual review of its neir program, as necessary.  In is not met as evidenced the facility document review, it at the facility staff failed to trol practices for three of the medication administration ent #34, 198 and #21; and for in the survey sample,  I ailed to ensure the medication and medication pass.  I ailed to ensure the medication and #21, were free from and medication pass.  I ailed to implement physician ecautions while in Resident	F 88	procedures to be followed during medication administration. All nursing staff will be inserviced of facility policy and procedure on infecontrol to include the proper use of for residents on isolation by the DO ADON and/or Regional Nurse Consultant.  Monitoring: The DON are responsible for maint compliance. The DON, ADON and designee will perform 2 random Medication pass audits to monitor compliance with medication administration and supplement administration. Any negative findings corrected at the time of discover disciplinary action taken as needed. The DON, ADON and/or Unit Markeiller perform random weekly audit residents on isolation precautions monitor nursing staff for compliant negative findings will be addressed time of discovery and disciplinary taken as warranted Aggregate find the reports will be submitted to the Quality Assurance Committee quality Assurance Committee quality policy and procedure.  Completion Date: 10/1/18	aining dior  for  for  for  mgs will  ry and  l.  mager  s of  to  nee. Any  d at  r action  lings of  e  arterly		

	AND PLAN OF CORRECTION I DENTIFICATION NUMBER:		touce interested	TIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
		495301	B. WING			C /23/2018		
	PROVIDER OR SUPPLIER	/AL		STREET ADDRESS, CITY, STATE, ZIP COI 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE		
F 880	COPD (chronic obsand high blood present MDS (minima quarterly assessment refere #34 was coded as ability to make daily possible 15 on the Mental Status) examember with bed mextensive assistant dressing, and person staff with toiletin On 8/22/18 at 5:07 administration was nurse) #2. RN #2 v following medicatio (1) Neurontin 100 m (2) Zantac 150 mg.  After these medical grabbed the rim of bare fingers and transporting medication (2) When the sident #34 is not Resident #34 is lips cup, where RN #2's On 8/22/18 at 5:14 conducted with RN should hold the meand transporting medication (3) where RN #2's could hold the cup is and transporting medication (4) where RN #2's cup, where RN #2's R	structive pulmonary disease), issure. Resident #34's most um data set) assessment was nent with an ARD ince date) of 7/10/18. Resident being cognitively intact in the decisions scoring 15 out of BIMS (Brief Interview for m. Resident #34 was coded as sistance from one staff member with onal hygiene; total dependence g and bathing.  p.m., medication conducted with RN (registered was observed preparing the ns for Resident #34:  Ing (milligrams) capsule tablet  Itions were prepared, RN #2 the medication cup with her ansported the medication to m. RN #2 gave the cup to the took the medications.  Were touching the rim of the share fingers had touched.  p.m., an interview was #2. When asked how nurses dication cup while preparing	30 .35	380				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		N N	IPLE CONSTRUCTION  NG	COMPLETED				
		495301	B. WING _		08	/23/2018		
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	<del></del>			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 880	would result in comaware the above of did not realize that cup by the rim. Rh have done that.  On 8/22/18 at 6:22 staff member) #1, the DON (Director of the above concerns of t	I that holding the cup by the rim tamination. RN #2 was made bservations. RN #2 stated she she had held the medication N #2 stated that she should not P. p.m., ASM (administrative the administrator, and ASM #2, of Nursing) were made aware erns.  Itiled, "Administering umented in part, the following: established facility infection is (e.g. handwashing, antispetic isolation, precautions, etc.) for of medications, as applicable."  Ition was presented prior to exit. It is defented the treatment of seizures the nerve pain. This information in The National Institutes of alm.nih.gov/pubmedhealth/PMH =details.		30				
	medication cups f	or Resident #198 and #21, were	•		2			

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AND DUAN OF CORRECTION IN THE PERSON NUMBER.		, M. 186	TIPLE CONSTRUCTION	COV	(X3) DATE SURVEY COMPLETED		
		495301	B. WING	100 W T	1	C /23/2018	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP CO 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630		20,2310		
(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	
F 880	free from contamination. Resident #198 was 8/17/18 with diagnot limited to left artificing pressure, and high did not have a comset) assessment arralert and oriented x diagnoses that include heart failure, demedisturbance, and hi #21's most recent hassessment was a assessment with arrotate) of 8/10/18. Reverely cognitively daily decisions scot (Brief Interview for On 8/22/18 at 5:20 administration was nurse) #1. RN #1 following medicatio (1) Aspirin 325 mg (2) Norco 5/325 mg (2) Norco 5/325 mg After these medicate grabbed the rim of bare fingers and transport Resident #198s room	admitted to the facility on uses that included but were not all knee joint, high blood cholesterol. Resident # 198 pleted MDS (minimum data and was documented as being 3 (person, place, time).  admitted to the facility with uded but were not limited to intia without behavioral gh blood pressure. Resident MDS (minimum data set) five day scheduled in ARD (assessment reference esident #21 was coded as impaired in the ability to make ring 07 out of 15 on the BIMS Mental Status) exam.  p.m., medication conducted with RN (registered was observed preparing the ins for Resident #198:	F8				

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Event ID: 6RF911

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495301	B. WING			C <b>23/2018</b>
NAME OF I	NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD	1 00	20/2010
HERITAGE HALL FRONT ROYAL				FRONT ROYAL, VA 22630		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ( (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO TH	D BE	(X5) COMPLETION DATE
F 880	on 8/22/18 at 5:30 empty medication of the rim of the cup, a protein powder and room. RN #1 then Resident #21's over contents of the Prowith water. RN #1 cup by the rim of the and gave the cup to drank the Pro-Stat I touched the rim of the fingers had touched hands.  On 8/22/18 at 5:35 conducted with RN should hold the meand transporting methe top and the inside		F8	80		
	she touched the rim Resident #21's med fingers, RN #1 state #1 was then made a observations. RN # aware that she had was an infection cou the medication cup. On 8/22/18 at 6:22 staff member) #1, the the DON (Director of of the above concer-	n of Resident #198's and dication cup with her bare ed that she was not sure. RN aware of the above 1 stated that she was not done that. RN #1 stated that it ntrol issue to touch the rim of p.m., ASM (administrative he administrator, and ASM #2, of Nursing) were made aware				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	FIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED			
		495301	B. WING	<u> </u>	1 0	C 08/23/2018		
	PROVIDER OR SUPPLIER  GE HALL FRONT RO	/AL	STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630			7 00/20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 880	(1) Aspirin- "Used to pain associated with This information ware Guide, 11th edition, (2) Norco- "Opioid a This information ware Institutes of Health. https://www.ncbi.nlr T0010590/?report= (3) Pro-Stat- Supple wound healing. This from The National I https://www.ncbi.nlr 95749/.  3. The facility staff fordered contact pre #96's room.  Resident #96 was a 12/20/16. Resident were not limited to curinary tract infection recent MDS (minimassessment with an date) of 6/6/18, code cognitively intact.  Review of Resident a physician's order of isolation due to ESE B-lactamase (1)).  Resident #96's com 6/11/18 documented for MRSA (3) and ESE Contact isolation"	o decrease mild to moderate in inflammatory disorders." is obtained from Davis's Drug p. 1087. Inalgesic used to treat pain." is obtained from The National m.nih.gov/pubmedhealth/PMH details. Intermental protein used for information was obtained	F 8	80				

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A495301  NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT BOYAL  C  08/23/2018  STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  400 WEST STRASBURG ROAD			495301	B. WING		Company Company	
HERITAGE HALL FRONT ROYAL	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 08/23	3/2018
FRONT ROYAL, VA 22630	HERITAGE HALL FRONT ROYAL			0 0000			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE  DEFICIENCY)    D PROVIDER'S PLAN OF CORRECTION (X5)   COMPLETI TAG   CROSS-REFERENCED TO THE APPROPRIATE DATE   DEFICIENCY   DEFICIENCY   CROSS-REFERENCED TO THE APPROPRIATE DATE	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETION
Continued From page 65 care plan failed to document information regarding contact isolation.  On 8/22/18 at 8:28 a.m., CNA #1 was observed in Resident #96's room and assisting the resident with a beverage. CNA #1 was not wearing a gown, mask or gloves. CNA #1 did not wash her hands before leaving the room.  On 8/22/18 at 1:38 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 was asked what she should do before entering and when leaving a contact isolation room. LPN #5 stated, "I'm going to use my protective gear which should be outside the room, put on whatever is suitable for the isolation. Knock on the door ask to enter the room. Before I leave, once I have done what I need to do, remove my stuff at the door to be able to wash my hands to leave the room."  On 8/22/18 at 2:12 p.m., an interview was conducted with CNA #1. CNA #1 was asked what she should do before entering a contact isolation room. CNA #1 stated, "Gown up, mask and gloves." CNA #1 was asked what she should do before leaving a contact isolation room. CNA #1 stated, "Take it off, put it in the isolation cants in the room" When asked if she should wash her hands, CNA #1 stated, "Uh huh."  On 8/22/18 at 6:15 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the regional nurse consultant) were made aware of the above findings.  The facility document titled, "Isolation- Categories of Transmission-Based Precautions"	F 880	care plan failed to de regarding contact is On 8/22/18 at 8:28 Resident #96's room with a beverage. Or gown, mask or glow hands before leaving On 8/22/18 at 1:38 conducted with LPN LPN #5 was asked entering and when room. LPN #5 state protective gear which put on whatever is so Knock on the door at I leave, once I have remove my stuff at my hands to leave to On 8/22/18 at 2:12 conducted with CNA she should do befor room. CNA #1 state gloves." CNA #1 was before leaving a constated, "Take it off, put the room" When as hands, CNA #1 state On 8/22/18 at 6:15 put the director of nurs nurse consultant) we findings.	document information solation.  a.m., CNA #1 was observed in m and assisting the resident in in a many and assisting the room.  p.m., an interview was in a contact isolation in in interview was in a contact isolation in in interview was in a contact isolation. In interview was in a contact isolation in interview was intervie	F 8	80		

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

Event ID:6RF911

Facility ID: VA0101

If continuation sheet Page 66 of 68

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495301	B. WING				C <b>23/2018</b>
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP CODE 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
F 880	to Standard Precautions for reside infected with midiransmitted by direct indirect contact with resident-care items environment4. Gladdition to wearing Standard Precaution non-sterile) when ecaring for a resident contact with infective material and wound before leaving their hygiene. After remethands, do not touch environmental surfactions. 5. Gown: We entering the Contact After removing the contact potentially contact	act Precautions; 1. In addition tions, implement Contact dents known or suspected to croorganisms that can be et contact with the resident or environmental surfaces or in the resident's oves and Handwashing: In gloves as outlined under ns, wear gloves (clean, entering the room. While the change gloves after having the material (for example, fecal drainage). Remove gloves form and perform hand oving gloves and washing to potentially contaminated aces or items in the resident's tear a disposable gown upon the Precautions room or cubicle. If you have greated environmental on was presented prior to exit.	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		INCRETE CATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495301	B. WING				C <b>/23/2018</b>	
NAME OF PROVIDER OR SUPPLIER  HERITAGE HALL FRONT ROYAL			STREET ADDRESS, CITY, STATE, ZIP 400 WEST STRASBURG ROAD FRONT ROYAL, VA 22630	CODE		20/2010		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD E APPROPI	BE	(X5) COMPLETION DATE	
F 880	all interactions that patient or potentiall patient's environme obtained from the whttps://www.cdc.go s/isolation-guideline (3) "Methicillin-resis (MRSA) causes a rand wound infection bloodstream infection death. Staph bacter of the most common healthcare-associal information was obtained.	is wear a gown and gloves for may involve contact with the y contaminated areas in the ent." This information was website: v/infectioncontrol/pdf/guideline es.pdf  stant Staphylococcus aureus range of illnesses, from skin ins to pneumonia and ons that can cause sepsis and eria, including MRSA, are one	F	880			191118	