STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495356	A. BUILDING _____ B. WING _____	C 09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 9/4/18 through 9/6/18. Significant Corrections are required for complaince with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. The census in this 194 bed facility was 118 during the survey.	E 000	**E001** **Corrective Action(s):** The Emergency plan has been reviewed and the Policy and Procedure for providing pharmaceutical supplies for patients and staff as well as the policy and procedure for providing sewer and waste disposal. A facility Incident and Accident form has been completed for this incident. The Facility has completed their Emergency Plan table top exercise on 9/28/18. A facility Incident and Accident form was completed for this incident.	
E 001 SS=C	Establishment of the Emergency Program (EP) CFR(s): 483.73 The [facility, except for Transplant Center] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section.* The emergency preparedness program must include, but not be limited to, the following elements: *[For hospitals at §482.15:] The hospital must comply with all applicable Federal, State, and local emergency preparedness requirements. The hospital must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. *[For CAHs at §485.625:] The CAH must comply with all applicable Federal, State, and local emergency preparedness requirements. The CAH must develop and maintain a comprehensive emergency preparedness program, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on staff interviews, the surveyor	E 001	**Identification of Deficient Practices & Corrective Action(s):** The entire Emergency Preparedness Plan has been reviewed to identify any missing or incomplete required items in the Emergency Plan. Any/All negative findings will be corrected at time of discovery and a facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The Administrator has reviewed the Emergency Preparedness Plan and reviewed the required items and training to be completed for compliance. **Monitoring:** The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to maintain compliance. **Completion Date:** 10/19/18	

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

TITLE: Administrator

(X6) DATE: 9/28/18

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

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E 001	Continued From page 1 determined that the facility's emergency plan did not address the following areas: 1. That the emergency plan included policies and procedures for the provision of pharmaceutical supplies for patients and staff. 2. Documentation that the emergency plan includes policies and procedures to provide sewage and waste disposal. 3 Documentation of the annual tabletop exercise The surveyor met with the administrator on 9/6/18 at 2 pm in the administrator's office and discussed the above areas of concerns. The administrator stated, "We are scheduled to have the tabletop exercise on 9/11/18."	E 001		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/4/18 through 9/6/18. Five complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 194 certified bed facility was 118 at the time of the survey. The survey sample consisted of 27 current Resident reviews and four closed record reviews	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		

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	495358	A. BUILDING _____ B. WING _____	C 09/06/2018

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F 578	Continued From page 2 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate DDNR (Durable Do Not	F 578	F578 **Corrective Action(s):** Residents #43 has had their DDNR form reviewed by the DON and the attending physician and it has been updated and correctly completed to reflect resident #43's code status. An Incident and Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Admission Director and/or Social Services Director will review all resident's medical records to ensure the DDNR is accurately filled out. Any negative findings will result in the Admission Director and/or Social Services Director to contact all responsible parties to verify each resident's code status and advance directives to insure that the proper status has been explained and that written notification has been placed in the medical record.	

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F 578	Continued From page 3 Resuscitate) for 1 of 31 residents in the survey sample (Resident #43). The findings included: The facility failed to have a complete and accurate DDNR (Durable Do Not Resuscitate) for Resident #43. Resident #43 was readmitted to the facility on 4/16/18 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, anxiety disorder, depression and psychotic disorder. On the quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/17/18, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 3 out of a possible score of 15. Resident #43 was also coded as being totally dependent on 1 or 2 staff members for dressing, personal hygiene and bathing. The surveyor conducted a clinical record review on Resident #43 on 9/5/18. During this review, it was noted by the surveyor that the DDNR dated for 11/21/17 was not filled out completely. Section 1 of the DDNR read in part, "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." The boxes beside #1 and #2 were blank The surveyor notified the administrative team on 9/5/18 at 5:08 pm in the conference room of the above documented findings	F 578	**Systemic Change(s):** The Facility policy and procedure was reviewed and no changes are warranted at this time. The Admissions Director has been inserviced on the proper completion of a DDNR and Advance Directives when required. The Admission Director will discuss with each future Admission their advance directors and resuscitation status upon admission to the facility. Any/all concerns expressed will be reported to the Administrator. The Administrator &Director of Nursing will speak to those concerned or with questions about each area & follow through on all concerns to ensure proper resuscitation status is reflected in the medical record. **Monitoring:** The Admission Director and Social Services Directorare responsible for maintaining compliance. The Admission Director and/or Social Service Director will audit all Residents medical records monthly to monitor compliance for having a current resuscitation order and/or advance directive Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date:** 10/17/18	

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F 578	Continued From page 4 No further information was provided to the surveyor prior to the exit conference on 9/6/18.	F 578		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580	**F580** **Corrective Action(s)** Resident #91's attending physician has been notified that facility failed to notify the physician of low blood pressures on multiple occasions as ordered. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents with physician ordered daily or weekly blood pressure orders may have potentially beenaffected. The DON, Unit Manager, QA Nurse will complete a 100% review of all residents with physician ordered blood pressure monitoring to identify resident at risk. All negative findings will be corrected at the time of discovery and the attending physician will be notified. A facility Incident & Accident form has been completed for this incident.	

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F 580	Continued From page 5 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to notify the physician of a change in condition for 1 of 31 residents in the survey sample (Resident #91). The findings included: The facility staff failed to notify the physician of a change in condition as related to low blood pressures for Resident #91. Resident #91 was readmitted to the facility on 4/15/15 with the following diagnoses of, but not limited to high blood pressure, dementia, anxiety disorder and depression. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/14/18 coded the resident as having short term and long-term memory problems with being moderately impaired in making daily decisions. Resident #91 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and	F 580	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The 24 Hour Report serves as the source document for communicating changes in condition, status, proper notification to the attending physicians and the responsible parties and revision/updates to the comprehensive plan of care. The 24 Hour Report will be reviewed and initialed daily by the Administrator, DON and Unit Manager.The Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Notification of Rights & Services and issued a copy of the facility policy and procedure. The inservice will include staff education on Physician and RP notification for any change in resident status, medications, treatments. **Monitoring:** The DON and Unit Managers are responsible for maintaining compliance. Weekly MAR audits will be completed weekly for residents with physician ordered blood pressure monitoring to monitor compliance. All Any/all negative findings will be corrected at time of discovery and appropriate disciplinary action taken. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date:** 10/1/18	

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F 580	Continued From page 6	F 580		

being totally dependent on 1 staff member for bathing.

The surveyor performed a review of Resident #91's clinical record on 9/5 and 9/6/18. During this review, the surveyor noted a physician order, which stated, "Blood pressures to be obtained daily". The physician dated this order for 2/17/17. The surveyor reviewed the blood pressures that were obtained and the following blood pressures were not reported to the physician:

9/4/18	10:58 am	91/60
8/24/18	11:42 am	96/63
8/7/18	02:19 pm	64/41
8/5/18	09:59 am	99/67
7/26/18	11:04 am	96/80
7/19/18	10:11 am	89/73
7/18/18	12:28 pm	98/72
7/13/18	09:48 am	87/52
6/29/18	10:53 am	95/65
5/26/18	10:09 am	96/68
5/24/18	09:54 am	98/68
5/10/18	09:41 am	98/62
5/5/18	10:47 am	90/62
5/4/18	09:49 am	93/63

The surveyor notified the administrative team on 9/5/18 at 5:08 pm of the above documented findings.

On 9/6/18 at 1 pm, the director of nursing (DON) stated to the surveyor that she had reviewed the blood pressures for this resident. The surveyor asked the DON if these low blood pressures should had been reported to the physician. The DON stated, "I would expect the nurses' to assess the resident from head to toe then call the physician." The surveyor asked the DON if there was documentation of a head to toe assessment

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F 580	Continued From page 7 documented in the nurses' notes on the dates the blood pressures were low. The DON stated, "No, I couldn't find any." No further information was provided to the surveyor prior to the exit conference on 9/6/18.	F 580		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the	F 583	**F583** **Corrective Action:** Resident # 12's RP was notified that facility staff and a facility vendor failed to knock on resident's door prior to walking into room to inspect equipment. A facility Incident and Accident Form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All residents may have been potentially affected. A 100% observation audit of all residents will be conducted by the Social Services, Activity and Nursing Administration to identify any residents at risk for staff and vendors not maintaining or respecting resident privacy while in their resident rooms. Any/all negative findings will be corrected at time of discovery and staff involved will receive immediate inservice training. An Incident & Accident Form will be completed for any/all incidents of exposure.	

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F 583	Continued From page 8 Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff and respiratory service vendor failed to respect Resident privacy for 1 of 31 Residents in the survey sample, Resident # 12. The findings included: A facility staff member and respiratory service vendor failed to knock on Resident # 12's door prior to entering her room. On 9/4/18 at 12:16 pm, the surveyor was in Resident # 12's room conducting an interview. While conducting the interview, a respiratory services vendor entered Resident # 12's room without knocking on the door prior to entering. The respiratory services vendor checked Resident # 12's bi pap machine. On 9/4/18 at 12:38 pm, a facility employee walked into Resident # 12's room without knocking prior to entering the room. The facility employee looked around in the room and walked back out of the room. On 9/6/18 at 8:12 am, the surveyor spoke with the facility administrator regarding the facility staff member and respiratory service vendor entering Resident # 12's room without knocking prior to entering the room. The surveyor asked the administrator if outside vendors receive any education and training regarding privacy prior to	F 583	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff and vendors that enter residents rooms will be inserviced by the Social Services director and/or DON on Resident Rights, Confidentiality and Personal Privacy to include maintaining and respecting resident privacy. **Monitoring:** The Administrator, DON and Social Service director are responsible for maintaining compliance. The DON, Social Service director and/or administrator will perform two weekly facility observation audits of the facility in order to maintain compliance. Any/all negative findings will be corrected immediately and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date:** 10/19/18	

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F 583	Continued From page 9 providing services to the facility. The facility administrator stated to the surveyor that the outside vendors are held to the same standards as the facility employees and this had been outlined within their contract. On 9/6/18 at 12:55 pm, the facility administrator provided the surveyor with a copy of the Respiratory services contract. The contract contained information that included but was not limited to: ..."All of the above listed services shall be conducted by the Vendor in accordance with recognized professional and ethical medical standards within terms and conditions of this Agreement and any and all applicable rules, regulations, policies and procedures of (cooperation's name withheld) including , but not limited to, the (cooperation's name withheld) Policy and Procedure Manual, and all subsequent amendments thereto (all of which are hereby incorporated by reference), and all applicable state, federal and local laws, rules and regulations." ... According to the facility policy on "Quality of Life - Dignity," the policy interpretation and implementation contains documentation that includes but is not limited to: "6. Residents' private space and property shall be respected at all times. a. Staff will knock and request permission before entering residents' rooms." No further information was provided to the survey team prior to the exit conference on 9/6/18.	F 583		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		

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F 684	Continued From page 10 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care for 2 of 31 residents in the survey sample (Resident # 33 and Resident #70). The findings included: 1. The facility staff failed to follow professional standards of care regarding documentation of administration times for insulin for Resident #33. Resident #33 was admitted to the facility on 4/2/18 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, diabetes, Alzheimer's disease, dementia, anxiety disorder and depression. On the significant change, MDS (Minimum Data Set) with ARD (Assessment of Reference Date) of 7/9/18 the resident was coded as having short term and long-term memory problems and was moderately impaired in daily decision-making skills. Resident #33 was also coded as being totally dependent on 1 or 2 staff members for dressing, personal hygiene and bathing. The surveyor performed a review of Resident #33's clinical record on 9/5 and 9/6/18. During	F 684	**F684** **Corrective Action(s):** Resident #33's attending physician was notified that the facility staff failed to accurately transcribe the physician ordered Accucheck and Sliding scale insulin order. A facility Medication Error form was completed for this incident. Residents #70's attending physicians was notified that the facility failed to notify the attending physician of elevated blood sugar levels above 400 as ordered by the physician. A facility Medication Error form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with Accucheck and Sliding scale insulin orders may have potentially been affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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	495356	A. BUILDING _____ B. WING _____	C 09/06/2018

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F 684	Continued From page 11 this review, the surveyor noted the following physician order on the MAR (Medication Administration Record) which stated, " ...Novolog 100 units/ml (milliliter) Flexpen SSI (Sliding Scale Insulin) as follows: BS (blood sugar) 0-70=0 U (units), Notify MD, 71-150=0 U, 151-180=2 U, 181-220=4 U, 221-250=6 U, 251-300=8 U, 301-350=10 U, 351-400=12 U, 401 or greater give 12 U and notify MD ..." The surveyor reviewed the MAR for the months of July, August and September 2018. The surveyor notified the director of nursing (DON) and regional nurse consultant on 9/6/18 at 1:30 pm. The DON stated, "That order doesn't have a frequency or times of the insulin to be administrated." The surveyor requested a copy for the facility's policy regarding medication orders and administration. At 2:45 pm, the surveyor received copies of the facility's policy titled, "Medication and Treatment Orders" which read in part as follows: " ...9 Orders for medications must include: a. Name and strength of the drug; b. Number of doses, start and stop date, and/or specific duration of therapy; c. Dosage and frequency of administration; d. Route of administration ..." No further information was provided to the surveyor prior to the exit conference on 9/6/18. 2. The facility staff failed to follow physician's orders for diabetic management for Resident #70. Resident #70's clinical record was reviewed on 9/5/18 at 9:00 AM. Resident #70 was admitted on 11/2/17. His diagnoses included heart failure, hypertension,	F 684	**Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications and treatments. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. To include following the Accucheck and sliding scale insulin orders per physician order. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly MAR audits on all residents with Accucheck and sliding scale insulin orders to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 10/1/18	

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F 684	Continued From page 12 diabetes, and depression. The latest MDS (minimum data set) assessment dated 8/6/18 coded the resident as cognitively unimpaired. He required nursing staff assistance for the majority of the ADLs (activities of daily living) Resident #70's CCP (comprehensive care plan) reviewed and revised on 8-8-18, documented his diabetic management interventions under ADLs Staff interventions included provide medications as ordered, accu-checks and insulin per orders and be alert to any s/s hyper/hypoglycemia. The latest physician's orders, signed and dated on 8/7/18, included, "Accu-checks AC & HS (before meals and hour of sleep).....BS (blood sugar) less than 70 or greater than 400 notify physician." The MAR (medication administration record) for August 2018 was reviewed and the resident's blood sugars were observed to be above 400 on three days: 1. 8/6/18 at 4:30 PM = 439 2. 8/18/18 at 4:30 PM = 400 3. 8/19/18 at 4:30 PM = 440 The clinical record did not contain documentation that the accu-checks/blood sugars had been reported to the physician per his orders. On 9/5/18 at 2:29 PM the DON was asked to provide evidence the physician had been notified of the accu-checks/blood sugars in question. The DON said there was no documentation the accu-checks had been reported to the physician	F 684		

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F 684	Continued From page 13 No additional evidence was provided prior to the survey team exit.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure a physician order was obtained prior to the administration of oxygen for 1 of 31 residents in the survey sample (Resident #62). The findings included: The facility staff to ensure a physician order was obtained prior to the administration of oxygen for Resident #62. Resident #62 was admitted to the facility on 4/18/18 with the following diagnoses of, but not limited to heart failure, high blood pressure, pneumonia, urinary tract infection, diabetes, stroke, depression and respiratory failure. On the quarterly MDS (Minimum Data Set) with ARD (Assessment Reference Date) of 7/25/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #62 was also	F 695	**F695** **Corrective Action(s):** Resident #62's attending physician was notified that the facility administered oxygen to resident #62 without a physician order. Resident #62's attending physician assessed and clarified resident #62's oxygen order. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON, ADON and/or Unit Manager to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery. A facility Incident & Accident form will be completed for each item discovered. **Systemic Change(s):** The facility policy and procedure for Oxygen administrationhas been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order.Inservices will include the delivery of oxygen per physician order and the monitoring oxygen flow rates throughout the shift.	

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F 695	Continued From page 14 coded as being totally dependent of 1 staff member for dressing and bathing. On 9/6/18 at 8:20 am, the surveyor went into the resident's room and observed the resident receiving oxygen at 4 liters/minute by nasal cannula. At 9:00 am, the regional nurse consultant and surveyor went back into the resident's room and observed the resident receiving oxygen at 4 liters/minute by nasal cannula. The surveyor and regional nurse consultant reviewed the resident's clinical record. The clinical record did not have a physician order for oxygen that the resident was receiving. The regional nurse consultant stated, "Let me look into this some more and I will get back to you with what I find out." At 10:00 am, the regional nurse consultant returned to the surveyor and stated, "The resident was discharged to the hospital and when she was readmitted to the facility, the staff didn't get an order to restart her oxygen." No further information was provided to the surveyor prior to the exit conference on 9/6/18.	F 695	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit manager will perform weekly audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed.All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 10/19/18	
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on facility staff interview, clinical record	F 697		

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F 697	Continued From page 15 review and in the course of a complaint investigation it was determined facility staff failed to provide pain management in accordance with professional standards of practice for 1 of 31 residents (Resident #275). Findings: The facility staff failed to provide pain management in accordance with professional standards of practice for 1 of 31 residents (Resident #275). Resident #275's clinical record was reviewed on 9/5/18 at 3:00 PM. Resident #275 was admitted to the facility on 6/7/17 and discharged on 6/10/17. The resident diagnoses included atrial fibrillation, diabetes, hypertension, depression, anxiety, lung mass (possibly malignant) coronary artery disease and congestive heart failure. The resident did not have a completed MDS (minimum data set) during her three day stay. Resident #275's initial care plan, initiated on 6/7/17 documented pain as a chief concern for this resident. The staff interventions included "....be alert to & assess for s/s (signs and symptoms) c/o (complaints) of pain....be alert to effectiveness of pain medication...." The initial/admission physician's orders, signed and dated on 6/9/17, included an order for "Fentanyl 25 mcg/hr patch apply one every three days. Rotate sites." This medication was consistent with that used at the discharging hospital during the resident's stay there, prior to the admission to the nursing home facility.	F 697	**F697** **Corrective Action(s):** Resident #275's attending physician was notified that the facility failed to address the residents pain levels or the residents pain management plan for approximately 8 hours. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents receiving scheduled or PRN pain medication may have potentially been affected. A 100% review of all residents receiving PRN or scheduled pain medications will be conducted by the DON, RCC and/or designee to verify a resident centered care plan is in place to address the residents pain levels and the residents pain management plan. All negative findings will be corrected at time of discovery, the attending physician will be notified of any pain management issues and a facility Incident & Accident form will be completed. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for following and administering medications per physician order. This includes reassessing residents after the administration of routine or PRN pain medications.	

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F 697	Continued From page 16 The MAR (medication administration record) for June 2017 documented the placement of a Fentanyl 25 mcg/hr patch on the resident on 6/8/17 9 AM. The corresponding nursing note documented, "6/8/17 at 12:31 PM..rsd (Resident's) daughter brought in fentanyl patch from home, MD notified. New orders, d/c/ current fentanyl patch and start apply fentanyl patch 25 mcg/hr apply one patch Q (every) three days. patch placed this morning approximately 8:30 AM to R upper back w/opsite dressing over in place. MD/RP aware." The nursing notes were reviewed and documented the resident was admitted to the facility on 6/7/17 at 2:49 PM. During an assessment conducted at 7:24 PM the Fentanyl patch was verified missing by nursing staff. The resident denied pain at that time. The resident told the staff the patch had been placed by hospital staff on the previous day on her right shoulder. Nursing staff notified the physician, who ordered Fentanyl patch 25 mcg/hr to be placed on 6/8/17 at 9 PM. No additional orders were received to address/manage the resident's pain in the interim. On 6/7/17 at 10:11 PM the nursing staff assessed the resident for pain. They documented the pain rating tool with no complaint or evidence of pain. On 6/8/17 at 6:24 AM the nursing notes documented the resident's daughter called the staff to the room to report her mother was having chest pain. The nurse provided two administrations of nitroglycerin and xanax 0.25 mg for anxiety.	F 697	**Monitoring:** The DON will be responsible for maintaining compliance. The DON. ADON and/or Unit Managers will audit resident MAR's weekly to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 10/19/18	

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F 697	Continued From page 17 No other pain management was provided by nursing staff until the family member arrived with the resident's Fentanyl patch from her home supply at 8:30 AM. The staff did not document pain monitoring between 10:11 PM (on 6/7/17) and 6:24 AM the following day. On 8/5/18 at 2:29 PM the administrator and DON were informed of the surveyor's findings and that the resident's pain had not been managed appropriately after staff realized the Fentanyl patch was missing upon admission from the hospital. No pain management was provided until the resident was reported by a family member to be in acute distress with chest pain the following morning. No additional evidence was provided prior to survey team exit. This was a complaint deficiency.	F 697		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility.	F 812		

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F 812	Continued From page 18 §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. The findings included: The dietary staff failed to ensure the walk=in freezer was working appropriately, dietary staff failed to ensure all of their hair was contained in the hairnets, and failed to ensure the 400 hall pantry was clean The surveyor entered the kitchen on 9/5/18 at 11:21 a.m. to check tray line temperatures. The surveyor observed the maintenance staff #1 standing on the opposite side of the tray line talking with a dining server. The maintenance staff #1 did not have a hairnet covering his hair. In addition, while in the kitchen, the surveyor observed two dining servers with strands of long hair hanging out from under their hairnets. One of the dining servers (#1) was observed trying to contain her hair in the hairnet. The surveyor asked what she should do after she put her hair back in the hairnet and she stated, "I'm going to wash my hands" and proceeded to the sink to do so. The surveyor also observed one of the dining servers (#2) attempting to open the walk-in freezer door and was having much difficulty in getting the door open. When the freezer door	F 812	**F812** **Corrective Action(s):** The Maintenance staff member #1 observed in the kitchen without a hairnet on and other dining server #1 have been inserviced on the proper use of a hair net anytime they enter the kitchen food preparation area. A facility Incident and Accident form was completed for this incident. The walk-in freezer identified with ice build-up during the kitchen tour has been inspected by the maintenance department and completely defrosted. A facility Incident and Accident form was completed for this incident. The 400 hall pantry identified with a strong odor has been thoroughly cleaned by environmental staff. A facility Incident and Accident form was completed for this incident **Identification of Deficient Practices & Corrective Action(s):** All other residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will randomly monitor the kitchen preparation area before, during and after meals to identify any negative findings. Any negative findings will be corrected at the time of discovering and disciplinary action will be taken as need. Environmental services will perform daily cleaning of all unit pantries. A facility Incident and Accident form will be completed for each of negative finding identified.	

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F 812	Continued From page 19 was finally opened, the surveyor and the administrator who was also in the kitchen observed an accumulation of ice all along the freezer door from the top to the bottom of the door and from side to side. The ice had the appearance of "icicles". The administrator stated the icicles could be from the humidity. The surveyor and the dietary manager observed the pantry on the 400 hall on 9/06/18 at 9:07 a.m. Upon entering the pantry, both the surveyor and the dietary services manager smelled a strong, pervasive odor of urine. Neither the surveyor nor the dietary services manager saw any evidence of urine. The dietary services manager stated the smell might be coming from the tall garbage can and she requested housekeeping services to check the pantry. The surveyor interviewed the maintenance staff #1 on 9/06/18 at 9.36 AM. The maintenance staff #1 stated he was given a "101" on wearing a hairnet when he goes into the kitchen. The surveyor also interviewed the dietary services manager on 9/6/18 at 3:36 p.m. regarding the hairnets and freezer with ice build=up. She stated she had educated the staff and stated the kitchen staff may have to go to a bonnet. The surveyor informed the administrator, the director of nursing, the corporate registered nurse and the administrator in training of the above concern during the end of the day meeting on 9/6/18 at 5:15 p.m. No further information was provided prior to the exit conference on 9/6/18.	F 812	**Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The CDM will inservice dietary staff on the proper sanitation, storage, cleaning and transportation of dietary products per established policy and procedure to include unit pantries In addition the inservice will cover the procedure for proper hair/beard net application at all times while in the kitchen area. The inservice will include all aspects of infection & sanitation control measures. **Monitoring:** The Dietary Manager is responsible for maintaining compliance. The Dietary manager perform 3 random kitchen pass audits and unit pantry audits weekly to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 10/1/18	

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F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	**F880** **Corrective Action(s):** The medical director was notified that the facility failed to implement a comprehensive infection control program and failed to accurately complete infection control tracking logs. A facility Incident & Accident form has been completed for this incident. The contract respiratory services vendor staff have been inserviced by the DON on the possible indirect-transmission of infectious agents by their clothing and equipment being placed on or touching multiple resident beds. An Incident & Accident form was completed for each incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A 100% review of all residents with infections will be conducted by infection control nurse to identify whether the status of the infections was being appropriately monitored, listed on the infection control tracking logs to monitor for trends, improvement, ongoing treatment or if they have been resolved. Any/all negative findings related to isolation precautions and infection control tracking and trending will be corrected at time of discovery and a facility Incident & Accident form will be completed.	

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	495356	A. BUILDING _____ B. WING _____	C 09/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BLACKSBURG	3610 SOUTH MAIN STREET BLACKSBURG, VA 24060

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F 880	Continued From page 21 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure an effective infection control program The findings included: 1. During the entrance conference on 9/4/18 the surveyor requested the infection control line list (tracking form for facility infections) from July, 2017 through July, 2018 from the director of nursing services.	F 880	**Systemic Change(s):** The facility Infection Control policy and procedure has been reviewed and no changes are warranted at this time. The Infection Control nurse and DON will be inserviced by the Regional Nurse Consultant on the facility's infection control policy and procedure and the infection tracking logs for maintaining proper infection control standards and prevention in the facility. All staff and vendors that enter residents rooms will be inserviced by the DON and/or Regional Nurse Consultant on the infection Control Policy to include not placing items or sit on residents bed during care or assistance to prevent the spread or infections. **Monitoring:** The DON is responsible for maintaining compliance. The facility has an infection control tracking log for monitoring and tracking infections to maintain compliance. The DONwill review the infection control tracking log weekly and review/report all findings to the Risk Management Committee for review and recommendations. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date:** 10/11/18	

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F 880	Continued From page 22 On 9/6/18 at 4:00 pm, the surveyor and the infection control nurse reviewed the infection control line listing form for the above documented months. The surveyor noted that the line listing did not have a resolution of each infection if they had been resolved or continued to be ongoing infection. The infection control nurse stated, "I just started this job about a month ago. But this information can easily be put in a column so that this will be complete going forward." At 4:20 pm, the regional nurse consultant was notified of the above documented findings. The regional nurse consultant stated, "We have been with or without an infection control nurse during the past year. The infection control nurse that is here now just started about a month ago." No further information was provided to the surveyor prior to the exit conference on 9/6/18. 2. Contracted respiratory Services vendors were observed by the surveyor placing their clipboards and backpack on a residents' bed while servicing respiratory care equipment. On 9/4/18 at 12:18 pm, the surveyor was in a room conducting an interview with a resident. The respiratory services vendors came into the room while the interview was being conducted to service the respiratory care equipment. The surveyor observed the respiratory service vendors place their clipboards and backpack on the resident roommate's unoccupied bed while providing service to the equipment. On 9/6/18 at 8:12 am, the surveyor spoke with the facility administrator and made him aware of the findings as stated above. The facility	F 880		

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F 880	Continued From page 23 administrator stated, "They know they are not supposed to do that." The facility administrator also stated that he would be contacting the respiratory care vendor to speak with them regarding this issue.	F 880		