STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(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 01/23/19 through 1/24/19. Corrections are required for compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey. The census in this 60 bed facility was 59 at the time of the survey. The survey sample consisted of 15 current resident record reviews and 3 closed record reviews	E 000		
E 022 SS=C	Policies/Procedures for Sheltering in Place CFR(s): 483.73(b)(4) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (4) A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. [(4) or (2),(3),(5),(6)] A means to shelter in place for patients, staff, and volunteers who remain in the [facility]. *[For Inpatient Hospices at §418.113(b):] Policies and procedures. (6) The following are additional requirements for hospice-operated inpatient care facilities only. The policies and procedures must address the following: (i) A means to shelter in place for patients, hospice employees who remain in the hospice.	E 022	**E022** **Corrective Action(s):** The Emergency plan has been reviewed and the Policy and Procedure for Sheltering Family members, Residents, Volunteers and staff during an emergency was located and reviewed by the Administrator and the Maintenance Director. A facility Incident and Accident form has been completed for this incident. **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.	3/7/19

RECEIVED
FEB 19 2019
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sabrina C. Jones — TITLE: Administrator — (X6) DATE: 2/11/19

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(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 022	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interviews it was determined the facility staff did not have specific policies and procedures to address sheltering family members and volunteers in place during emergency. Findings: On 1/24/19 at 11:30 AM the facility administrator and MD (maintenance director) were interviewed regarding the facility's EP (emergency preparedness) program and staff training for same. The administrator had several suggestions when asked about sheltering staff, residents and family members in place during emergencies. She did not have policy dedicated to sheltering in place on file. No additional info was provided.	E 022	**Systemic Change(s):** Current facility policy & procedure for sheltering in place 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. All staff will be inserviced by the administrator on the policy and procedure for the sheltering in place of family members, residents, volunteers and staff during emergencies if required. **Monitoring:** The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is in compliance. **Completion Date:** 3|7|19	
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) (1) Training program. The [facility, except CAHs, ASCs, PACE organizations, PRTFs, Hospices, and dialysis facilities] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospitals at §482.15(d) and RHCs/FQHCs at §491.12:] (1) Training program. The [Hospital	E 037	**E037** **Corrective Action(s):** RN #1, LPN #1 and C.N.A. #1 have received one-on-one inservice training on the Emergency plan from the administrator and were able to provide return demonstration on the process for resident evacuations and the sharing of resident health information with other facilities during emergency evacuations. A facility Incident and Accident form has been completed for this incident.	3|7|19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(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 037	Continued From page 2 or RHC/FQHC] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least annually. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency	E 037	**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):** The Emergency Preparedness Plan has been reviewed and no changes are warranted at this time. The Administrator will inservice all facility staff on the Emergency Preparedness Plan and reviewed the procedure for resident evacuation during emergencies as well as, the process for sharing resident with other facilities and providers during and emergency evacuation. **Monitoring:** The Administrator is responsible for maintaining compliance. The administrator will monitor and review the Emergency Preparedness Plan quarterly with the QA committee to ensure the EOP is complete and in compliance. **Completion Date:** 3/7/19 RECEIVED FEB 19 2019 VDH/OLC	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(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 037	Continued From page 3 procedures. (iv) Maintain documentation of all emergency preparedness training. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. *[For CAHs at §485.625(d):] (1) Training program. The CAH must do all of the following:	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(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 037	Continued From page 4 (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least annually. This REQUIREMENT is not met as evidenced by: Based on facility policy review and staff interviews it was determined the facility staff failed to demonstrate staff knowledge of emergency procedures. The findings included: On 1/24/19 at 11:30 AM the facility administrator and MD (maintenance director) were interviewed regarding the facility's EP (emergency preparedness) program and staff training for	E 037		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(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 037	Continued From page 5 same. The administrator presented evidence the facility staff had several inservices regarding the new EP initiative and presented the sign-off sheets as proof of training. On 1/24/19 at 12:45 PM, RN I, LPN I and CNA I were interviewed about tracking resident evacuations and sharing resident information with other facilities during emergency evacuations. The three staff members were at the nursing desk at the time of the interview. LPN I pulled out the EP handbook kept at the desk–but could not find out how a resident's information was to be prepared or sent during an evacuation. The nursing staff members could not find any of the forms or inforamation necessary to track residents during an evacuation. RN I stated, "I know we send the clinical record out with the resident, but I'm not sure how we protect the info in that situation. We need to know the answers to that." The facility administrator and DON were informed of these findings at 1:00 PM. The administrator said maybe she should go ask questions and request a return demonstration from nursing staff after in-servicing them to determine they understood the process. No additional info was provided.	E 037		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey conducted 01/23/19 through 01/24/19. One complaint was 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.	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 6 The census in this 60 certified bed facility was 59 at the time of the survey. The final survey sample consisted of 15 current Resident reviews and 3 closed record reviews.	F 000		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to	F 622	**F622** **Corrective Action(s):** The facility staff failed to provide a copy of the comprehensive care plan goals for resident #210 when they were transferred to the emergency room. A facility Incident & Accident Form has been completed for each resident involved. **Identification of Deficient Practices/Corrective Action(s):** All other residents discharged and/or transferred from the facility may have been affected. The DON/designee will conduct a 100% audit of all residents who have been discharged and/or transferred from the facility in the past 30 days to identify residents that did not have the required documentation submitted to the receiving facility. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The DON and/or Regional Nurse Consultant will inservice facility licensed staff on the documentation required to be submitted to the receiving facility when a resident is being transferred or discharged to the hospital or other outside health care facility/provider.	3|7|19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 7 § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F 622	**Monitoring:** The DON/designee will be responsible for maintaining compliance. The DON and/or designee will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery. 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:** 3/7/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 8 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that a copy of the comprehensive care plan goals were sent upon transfer to the emergency room for 1 of 18 Residents in the survey sample, Resident # 210. The findings included: The facility staff failed to ensure that a copy of the comprehensive care plan goals were sent with Resident # 210 upon transfer to the emergency room on 3/14/18. Resident # 210 was an 82-year-old male who was admitted to the facility on 3/6/18. Diagnoses included but was not limited to: cognitive communication deficit, coronary artery disease, and dementia. The clinical record for Resident # 210 was reviewed on 1/23/18 at 10:30 am. The most recent MDS (minimum data set) assessment was a discharge assessment with an ARD (assessment reference date) of 3/14/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 210 had a BIMS (brief interview for mental status) score of 0 out of 15, which	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 9 indicated that Resident # 210's cognitive status was severely impaired. The plan of care for Resident # 210 was reviewed and revised on 3/12/18. The facility staff documented a focus area for Resident # 210 as "Falls: Resident is at risk for falls r.t (related to) dx (diagnosis) of muscle weakness and dementia. Resident has a w.c (wheelchair) used for locomotion." Interventions included but was not limited to: "Assist resident as needed with ADLs (activities of daily living), transfers, and mobility," and "Personal alarm." An order was written on 3/14/18 at 12:45 am. The order for Resident # 210 was documented as "Send out to (Facility name withheld) ER (emergency room) 911 for eval/tx (treatment) 3/13/18 mobile x ray results right femoral neck fracture." The surveyor did not locate any documentation that reflected that a copy of the comprehensive care plan goals were sent with Resident # 210 upon transfer to the emergency room on 3/14/18. On 1/24/19 at 1:00 pm, the surveyor spoke with the director of nursing and asked if she could provide documentation to support that a copy of the comprehensive care plan goals were sent with Resident # 210 upon transfer to the emergency room on 3/14/18. On 1/24/19 at 1:46 pm, the director of nursing made the surveyor aware that she was unable to locate documentation that reflected that a copy of the comprehensive care plan goals were sent with Resident # 210 upon transfer to the emergency room on 3/14/18. On 1/24/19 at 2:00 pm, the administrative team	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 622	Continued From page 10 was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 1/24/19.	F 622		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F 623	**F623** **Corrective Action(s):** Resident #210 is no longer in facility. The facility failed to provide a written notice for the transfer to the emergency room on 3/14/18.An Facility Incident & Accident form was completed for this incident. **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 will conduct a 100% audit of all residents who have been discharged and/or transferred in the past 60 days. Residents identified at risk will be corrected at time of discovery and the required notifications to the residents' responsible party and the state ombudsman will be made. A facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** Facility policy and procedures have been reviewed. No revisions are warranted at this time. The Administrator and/or Regional Nurse Consultant will inservice the facility's social worker(s) and nursing administration on the requirement that a resident's responsible party and the state ombudsman be notified of resident discharges/transfers.	3|7|19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 11 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy	F 623	**Monitoring:** The Social Services Director will be responsible for maintaining compliance. The Social worker, and/or Admissions Director will conduct chart audits weekly of all residents who have been discharged and/or transferred from the facility. 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:** 3\7\19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 12 for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This Requirement is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to give written notice of reason for transfer and discharge for 1 of 18 Residents in the survey sample, Resident #210. The findings included: The facility staff failed to ensure that the Resident # 210 and his representative received a written notice for reason of transfer to the emergency room on 3/14/18. Resident # 210 was an 82-year-old male who was admitted to the facility on 3/6/18. Diagnoses included but was not limited to: cognitive communication deficit, coronary artery disease, and dementia. The closed clinical record for Resident # 210 was reviewed on 1/23/18 at 10:30 am. The most	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 13 recent MDS (minimum data set) assessment was a discharge assessment with an ARD (assessment reference date) of 3/14/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 210 had a BIMS (brief interview for mental status) score of 0 out of 15, which indicated that Resident # 210's cognitive status was severely impaired. The plan of care for Resident # 210 was reviewed and revised on 3/12/18. The facility staff documented a focus area for Resident # 210 as "Falls: Resident is at risk for falls r.t (related to) dx (diagnosis) of muscle weakness and dementia. Resident has a w.c (wheelchair) used for locomotion." Interventions included but was not limited to: "Assist resident as needed with ADLs (activities of daily living), transfers, and mobility," and "Personal alarm." An order was written on 3/14/18 at 12:45 am. The order for Resident # 210 was documented as "Send out to (Facility name withheld) ER (emergency room) 911 for eval/tx (treat) 3/13/18 mobile x ray results right femoral neck fracture." The surveyor did not locate any documentation that Resident # 210 or Resident # 20's representative was made aware in writing of the reason for transfer to the emergency room on 3/14/18. On 1/24/19 at 1:00 pm, the surveyor spoke with the director of nursing and asked if she could provide documentation to support that Resident # 210 and his representative was made aware in writing of the reason for transfer to the emergency room on 3/14/18. On 1/24/19 at 1:46 pm, the director of nursing	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 14 made the surveyor aware that she was unable to locate documentation that reflected that Resident # 210 and his representative was made aware of the reason for transfer to the emergency room on 3/14/18. On 1/24/19 at 2:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 1/24/19.	F 623		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 761	**F761** **Corrective Action(s):** The identified bottle of expired Tuberculin solution was removed from the medication refrigerator and discarded. The Medication Refrigerator was thoroughly cleaned and defrosted. A Facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** The unit medication room, medication refrigerator and medication carts used for the storage medications may have been potentially affected. The DON, ADON and/or Unit Manager will conduct a 100% review of the medication room, Medication carts, and medication refrigerator to identify any expired or undated medications and any items requiring cleaning. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident Form will be completed for each incident identified.	3/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15 This Requirement is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to dispose of an expired medication and failed to store drugs in a sanitary environment in 1 of 1 medication rooms. The findings included: The facility staff failed to discard expired Tuberculin solution and failed to ensure that the refrigerator in the medication room was clean and defrosted. On 1/23/19 at 9:55 am, the surveyor reviewed medication room along with the unit manager, LPN # 1 (licensed practical nurse). The surveyor observed mildew on the upper strip of the medication refrigerator. The surveyor brought the mildewed area that was observed on the upper strip of the medication refrigerator to the attention of LPN # 1. LPN # 1 observed the area and agreed that there was a mildew on the upper strip of the medication refrigerator. The surveyor also observed a large amount of ice in the freezer area of the medication refrigerator. LPN # 1 observed the large amount of ice in the freezer area of the medication refrigerator and agreed that the refrigerator needed to be defrosted. The surveyor reviewed the medications that were in the medication refrigerator. The surveyor observed an opened vial of Tuberculin Purified Protein Derivative, Diluted Aplisol 5TU (titer unit)/0.1 ml (milliliter) solution with opened date of 11/27 written on the box. The surveyor showed LPN # 1 documentation that was written on the box of Tuberculin solution that stated, "Once entered vial should be discarded after 30 days." LPN # 1 agreed that the Tuberculin solution had not been discarded appropriately.	F 761	**Systemic Change(s):** Facility policy and procedure for medication and biological storage have been reviewed and no changes are warranted at this time. All licensed nurses will be inserviced by the DON on the facility policy and procedure for storing medications and biologicals. The nursing staff will also be inserviced on the Medication Administration Policy and Procedure to include weekly review of all refrigerated medications to include injectables and unrefrigerated medications and biologicals that may be expired or opened with no date. In addition, The Pharmacy consultant will check each medication room for improper storage of medications monthly during scheduled visits **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or unit manager will perform weekly Medication room audits to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and disciplinary action taken as appropriate. Results of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3|7|19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 16 The facility policy on "Disposal/Destruction of Expired or Discontinued Medication" contained documentation that included but was not limited to, ..."Procedure 4. Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction." ... The facility policy on "Storage of Medications" contained documentation that included but was not limited to, ..."9. Medications requiring refrigeration must be stored in a refrigerator located in the drug room at the nurses' station or other secured location. Medications must be stored separately from food and must be labeled accordingly. The medication room refrigerator should be cleaned weekly and kept free of ice buildup." ... On 1/24/19 at 2:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 1/24/19.	F 761		
F 810 SS=D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This Requirement is not met as evidenced by: Based on observation, resident and staff interview and clinical record review it was	F 810	**F810** **Corrective Action(s):** Resident #19 has been reassessed by occupational therapy for the appropriate adaptive eating equipment. Resident #19's meals are now served with the appropriate adaptive utensils. Her comprehensive care plan has been revised to reflect approaches and interventions to meet his resident specific needs.	3/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 810	Continued From page 17 determined the facility staff failed to provide Resident #19 with physician ordered adaptive eating equipment. Findings: Resident #19 was admitted to the facility on 1/16/17. Her diagnoses included diabetes, atrioventricular block, dysphagia, hypertension and obstructive sleep apnea. Resident #19's physician's orders, signed and dated on 6/27/17, stated, "Adaptive utensils at meals (built-up utensils) as requested." The latest MDS (minimum data set) assessment, dated 11/23/18, coded the resident as cognitively unimpaired. She could eat her meals with set-up and over site by staff members. She was coded with limited ROM (range-of-motion) in upper and lower limbs, bilateral. The CCP (comprehensive care plan), reviewed and revised on 1/22/19, documented the resident at risk for continued health concerns due to her refusal to get out of bed and refusing to sit up to eat. The interventions included, "Adaptive utensils at meals as requested per MD order." On 01/23/19 at 01:06 PM the surveyor gowned, gloved and masked to enter Resident #19's room and observed the resident eating unassisted. She had regular utensils with this meal. The resident told the surveyor should have been getting the adaptive equipment for meals, but did not receive it for that meal. The tray card said, "Adaptive utensils at meals". On 01/23/19 at 01:35 PM the DON was asked	F 810	**Identification of Deficient Practices & Corrective Action(s):** All other residents requiring adaptive eating equipment may have potentially been affected. The Occupational therapists will screen all residents requiring adaptive equipment needs to ensure the appropriate items are being used at meal times. Any/all negative findings will be corrected at time of discovery and the required adaptive equipment during meals will be forwarded to the CDM and the DON. A Risk Management Incident Accident Forms will be completed for each resident identified. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The dietary and nursing staff will be inserviced by the therapy department on the purpose and importance of using adaptive equipment during meals. An adaptive equipment book will be established and kept in the dietary department that identifies each residents requiring adaptive equipment at meals and the type of equipment to be utilized.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 810	Continued From page 18 about the adaptive equipment. She stated, "If memory serves it is a thick handled fork or spoon that she uses as she wishes. I beleive she has them in her room and uses them when she wants to." She went to check the room and see if resident had them. The DON reported to the surveyor the resident did not have/receive adaptive equipment for the lunch meal, but said she could eat her sandwich without it. The DON said she interpreted the order to be "as needed" but she didn't request it. On 01/23/19 at 01:54 PM the DON reported the kitchen dietary manager said she thought the resident had the rubber utensils in her room so she could use them as she wished. "They didn't know she didn't have them in her room, so they are going to send the built-up utensils in on her tray from now until the order is canceled. Resident did get a sandwich for lunch--but she still had soup and pears requiring the use of equipment she didn't have." The facility policy for assistance with meals was reviewed. It contained , "Adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups. On 1/23/19 at 4:00 PM this information was reported to the administrator. No additional information was provided.	F 810	**Monitoring:** The Dietary Manager is responsible for maintaining compliance. The Dietary Manager will perform weekly audits of adaptive equipment to monitor for compliance. All negative findings will be corrected at time of discovery. Disciplinary action will be taken for each negative finding as warranted. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date:** 3/7/19	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 19 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. §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, staff interview, clinical record review, and facility document review, the facility staff failed to prepare, store, and distribute food under sanitary conditions in the dietary department and for 2 of 18 Residents, Residents #40 and #45. The findings included: 1. The facility failed to dispose of expired milk and the #2 refrigerator had an inside temperature of 50 degrees. This refrigerator was in use at the time of the survey. On 01/23/19 at approximately 9:35 a.m., the surveyor toured the dietary department (kitchen) with the dietary manager. The refrigerator included milk with an expiration date of 01/22/19. The dietary manager placed the loose cartons of expired milk together in a	F 812	**F812** **Corrective Action(s):** The expired milk identified in refrigerator #2 during the initial kitchen tour was immediately removed and disposed of. A facility Incident and Accident form was completed for this incident. The refrigerator #2 was inspected and repaired by the facility maintenance staff. The defrost cycles were adjusted to prevent the unit from freezing up and icing the fan units. All food items stored in the refrigerator at inappropriate temperatures were disposed of. A facility Incident and Accident form was completed for this incident. C.N.A. #1 & #2 involved with the lunch pass and handling prepared food without gloves have received one-on-one inservice training from the DON on proper infection control practices and the proper handling of prepared food when assisting residents with their meals. A Facility Incident & Accident form has been 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 inspect the refrigerator and freezer to identify any expired food or milk products and to ensure proper function. Any negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each negative finding identified.	3/7/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 20 cardboard case that held 48 cartons. The dietary manager stated there was 45 cartons of milk in this box and she would dump them. Refrigerator #2 had an outside temperature of 41 and an inside temperature of 50 degrees. The dietary manager stated the inside of the refrigerator felt warm and she would have it checked. This refrigerator contained pimento cheese, mayonnaise, pot roast, bacon, lettuce, spaghetti sauce, pickles, cherries, relish, uncooked oatmeal, turkey, and BBQ sauce. On 01/23/19 at 11:22 a.m., the maintenance director stated he was attempting to adjust the thermostat and stated the inside temperature was reading 52. The maintenance director stated he did not know if the inside temperature was correct. However, they were going to clean out the refrigerator until they knew which temperature reading was the correct one. On 01/23/19 at 3:22 p.m., the maintenance director verbalized to the surveyor that the coils were frozen in the top of the refrigerator and they had thrown all the items in the refrigerator in the trash. The maintenance director stated due to the coils being frozen it was not circulating air. On 01/24/19, the maintenance director provided the surveyor with a copy of the work order regarding the refrigerator. Problem description "Reach in Fridge-evaporator. Coil is Freeing Up." Work description "Once I got there customer had already thawed ice off coils. And had cleaned coils. So I plugged unit back up and started it up and checked running operation and there were no access fittings to check pressures. Temp in cooler was 59 degrees after running about 20 minutes it pulled temp down to set point of 32.5	F 812	The DON and/or DON will monitor the lunch meal pass for 3 days to identify any negative findings with the tray pass or meal set up. All negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each negative finding identified. **Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The Dietary Manager will inservice the dietary staff on the proper preparing, storing and distribution of food under sanitary conditions, to include ensuring all expired foods items are removed from distribution and that the temperatures are in the appropriate range for the refrigerator and freezer. All nursing staff will be inserviced on the policy and procedure for proper meal tray pass and assistance. Tio include wearing gloves prior to touching resident food items.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 21 degrees. Then I watched it cycle as it maintained set point..." The issues in the kitchen were reviewed with the administrative staff on 01/23/19 at 4:34 p.m. and again on 01/24/19 at 2:00 p.m. No further information regarding these issues were provided to the survey team prior to the exit conference. 2. Based on observation, and resident interview it was determined the facility staff failed to serve meals in a clean and sanitary manner for 2 of 51 residents in the survey sample(Residents #40 and #45). On 1/23/19 at 12:45 AM the surveyor did a dining observation in the main dining room. Staff were observed to hand out trays and assist residents to set up their meals. CNAs I and II were observed to set up meals for Residents #40 and #45. The CNAs were cutting up sandwiches for the residents. They were observed to perform this task with their bare hands, without donning gloves prior to touching the resident's food. The surveyor asked for and received a copy of the facility policy for safety and sanitation which addressed glove use during meal service. The policy included "".....When direct contact with food occurs, gloves must be worn. Before handling ready-to-eat foods such as salads, fruit, sandwiches, meats, bread, or ice, put on gloves as a barrier to the bacteria on hands....." The facility administrator was informed of this observation on 1/23/19 at 4:12 PM.	F 812	**Monitoring:** The Dietary Manager and the DON are responsible for maintaining compliance. The Dietary manager will complete the Dietary food storage audit tool daily to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The DON, ADON or Unit Manager will monitor 3 random meal passes a week 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:** 3|7|19	
F 880	Infection Prevention & Control	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880 SS=D	Continued From page 22 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: (A) The type and duration of the isolation,	F 880	**F880** **Corrective Action(s):** LPN #1 involved in the Treatment Pass Observation for Resident's #24 has received one-on-one inservice training on proper infection control practices to be followed during a dressing change. A Facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents who receive a dressing change may have potentially been affected. The DON, ADON and/or Unit Manager will conduct a 100% audit of all dressing change treatments on all licensed nursing staff to observe proper infection control practices and proper hand washing during the treatment pass administration procedures. Any negative findings will be addressed immediately, and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no changes are warranted at this time. All licensed staff will be inserviced on the facility policy and procedure for proper infection control practices during medication and treatment procedures by the DON and/or Regional Nurse Consultant.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This Requirement is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to perform hand washing appropriately during wound care. Findings: Resident #24 was admitted to the facility on 11/27/18. Her clinical record was reviewed on 1/23/19 at 2:00 PM. The resident's latest MDS (minimum data set) dated 12/23/18 coded the resident as cognitively intact. She was coded with a stage IV pressure	F 880	**Monitoring:** The DON is responsible for maintaining compliance. The DON, Unit Manager and/or designee will perform 2 random weekly Treatment Pass audits to monitor nursing staff for compliance. Findings of the audits will be reported to the QA Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** 3/7/19	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495242	A. BUILDING _____ B. WING _____	C 01/24/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL - BROOKNEAL	633 COOK AVENUE BROOKNEAL, VA 24528

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24 ulcer. 01/23/19 at 1:30 PM LPN I is in the resident's room to change the dressing on her back. The dressing is observed on the right side of her buttocks. The dressing is saturated with drainage and is not dated. LPN I got the dressing materials together to change the dressing. The facility DON was to assist with the wound care. LPN I notes the pressure ulcer is a stage 4 and the wound doctor had changed it yesterday onsite. LPN I washed her hands and donned gloves. LPN I cleaned the wound with derma clenz in a clockwise motion inner to outer edges. She then placed a 4x4 gauze soaked in Dakins inside the wound. LPN I did not change her gloves or wash/clean hands between cleaning the wound and placing 4x4 with Dakins packed into wound. The surveyor informed the LPN and DON she did not wash her hands in between cleaning the dressing and packing with gauze and placing outer dressing on wound. The surveyor asked for policy on wound care and hand washing. The facility policy for handwashing/hand hygiene was reviewed. It contained instructions to the nursing staff to wash their hands and don gloves, ".....Before handling clean or soiled dressings, gauze pads, etc.....After handling used dressings contaminated equipment.....) The administrator was informed on 1/23/19 at 2:00 PM.	F 880		