Our Family Exists To Care For Yours.

Heritage Hall of Lexington • 205 Houston Street • Lexington, VA 24450 • (P) 540.464.8181 • (F) 540.464.8184

March 1, 2019

Center for Quality Health Services & Consumer Protection
Division of Long Term Care Services
9960 Mayland Drive – Suite 401
Attn: Nicole Keeney, Long Term Care Supervisor
Richmond, VA 23233-1463

Ms. Keeney;

Attached to this cover letter you will find Heritage Hall – Lexington's Plan of Correction and our credible allegation of compliance. The Plan of Correction addresses the corrective action, identification of deficient practices, systemic changes, and monitoring that will be implemented to address deficient practices identified during the annual survey.

If I can be of further assistance don't hesitate to contact me at (540) 464-8181.

Sincerely;

Tim Lawrence

Tim Lawrence
Administrator

HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS
Managed by AMERICAN HEALTHCARE, LLC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 02/12/19 through 02/14/19. The facility was in substantial compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 02/12/2019 through 02/14/2019. 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 60 certified bed facility was 54 at the time of the survey. The survey sample consisted of 14 current Resident reviews and three closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F550** **Corrective Action(s):** C.N.A. #1 involved in feeding residents #22 & #30 has been inserviced on resident Rights and Dignity regarding feeding residents individually, proper use of gloves when handling food items and proper hand washing after assisting with meals. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have the potentially been affected. The Administrator and DON will assess the dining experience and process for meal delivery in the dining room to establish a formal tray set up, delivery and feeding	3/18/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tim Lawrence | TITLE: Administrator | (X6) DATE: 3/1/19

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.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, facility staff failed to ensure a dignified dining experience for two residents in the main dining room, Residents #22 and #30. CNA #1 (certified nursing assistant) was observed feeding Residents #22 and #30 simultaneously during lunch on 02/12/2019. Findings included: During the dining observation on 02/12/2019 at 12:36 p.m. in the main dining room, CNA #1 was	F 550	assistance process to ensure nursing staff are providing a dignified dining experience and providing assistance with their meal trays in a timely manner. **Systemic Change(s):** Facility policy and procedures were reviewed. No changes are warranted at this time. The DON and/or Social Services will inservice nursing staff on facility policy and procedure regarding resident rights and dignity. The inservice will also cover the procedure for proper meal tray delivery and assistance to ensure all residents are served in a timely manner and receive meal assistance at the same table. **Monitoring:** The DON and Administrator are responsible for compliance. The DON or Administrator and/or designee will complete the 3 meal pass audit weekly to monitor for compliance. All negative findings will be corrected at the time of discovery. The audit findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: March 18, 2019**	

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F 550	Continued From page 2 observed feeding Residents #22 and #30 simultaneously. The CNA was not wearing gloves and did not wash her hands or use hand sanitizer during this observation. CNA #1 was interviewed on 02/13/2019 at 08:20 a.m. regarding the lunch observation on 02/12/2019. CNA #1 stated, "[Name] Resident #30 is a feeder. [Name] Resident #22 is not. She just needs to be cued, but yesterday she was struggling a little, so I would help her. I was feeding [Name] Resident #30, but helping [Name] Resident #22 also. I know I'm not supposed to feed two at the same time. I was just trying to get her to eat." The facility policy "Assistance with Meals" was requested and received on 02/14/2019 at 1:00 p.m. The policy included, "Residents shall receive assistance with meals in a manner that meets the individual needs of each resident...Dining Room Residents: ...3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity..." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 02/14/2019 at 1:10 p.m. The DON stated, "My expectation is they would feed one person at a time." No further information was received by the survey team prior to the exit conference on 02/14/2019.	F 550		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must	F 657	**F-657** **Corrective Action(s):** Resident #12's comprehensive care plan has been reviewed and revised to reflect specific interventions and approaches for the care and treatment of penile erosion	3/18/19

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F 657	Continued From page 3 be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to– (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to review and revise a CCP (comprehensive care plan) for one of 17 residents in the survey sample, Resident #12. Facility staff failed to include interventions for care and treatment of penile erosion on Resident #12's CCP. Findings included:	F 657	related to long term Foley catheter use. A Risk Management Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** Any/all male residents with a Foley Cather may have potentially been affected. A 100% review of all male resident comprehensive care plans will be conducted by the RCC and/or designee to identify residents at risk. Residents identified at risk as having an inaccurate comprehensive care plan will be corrected at time of discovery and a Risk Management Incident & Accident Form will be completed for each incident identified. **Systemic Changes:** The assessment process will continue to be utilized as the primary tool for developing comprehensive plans of care. The RCC is responsible for implementing the RAI Process. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record/physician orders will be used to develop and revise comprehensive plans of care. The Regional Nurse Consultant will provide in-service training to the interdisciplinary care plan team on the mandate to develop individualized care plans within 7 days of the completion of the comprehensive assessment and/or revisions to the comprehensive care plan as indicated with any changes in condition. **Monitoring:** The RCC and DON are responsible for maintaining compliance. The interdisciplinary team will audit all comprehensive care plans prior to	

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F 657	Continued From page 4 Resident #12 was originally admitted to the facility on 12/31/2013 and readmitted on 11/21/2018 with diagnoses including, but not limited to: Obstructive and reflux uropathy, Benign prostatic hyperplasia, Retention of urine and Diabetes Mellitus Type 2. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) 10/01/2018. Resident #12 was assessed as severely impaired in his cognitive status with a total cognitive score of four out of 15. On 02/13/2019 at 8:00 a.m. LPN #1 (licensed practical nurse), wound care nurse, and this surveyor, assessed Resident #12's penis and Foley catheter. Resident #12's urinary meatus was split from the opening of his penis to the start of his penile shaft. Catheter tubing was secured to his right thigh and the drainage bag was hanging on the right side of the bed, below the bladder. Resident #12 denied pain from the catheter. Resident #12's clinical record was reviewed on 02/13/2019 at approximately 8:30 a.m. Urology visit notes included the following documentation: 03/08/2018 - "...he has had foley several months and has penile erosion. Urethral erosion. Foley in several months, with erosion ventrally up 50% of shaft. Consideration for sp [suprapubic] tube is made..." 06/21/2018 - "...Urinary Retention & Penile Erosion...Significant erosion...I do not feel SP tube is indicated now..."	F 657	finalization coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: March 18, 2019**	

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F 657	Continued From page 5 09/27/2018 - "...No change in penile erosion..." 12/13/2018 - "...Penile erosion stable. Cont [continue] monthly tube change. Continue to affix to leg. Watch device & ensure tube/foley is not kinked..." 01/17/2019 - "...He had gross hematuria and went to ER [emergency room]...Change Foley per routine. We might consider imaging if this recurs." The current POS (physician order sheet) dated February 2019 included the following orders: "...Order Date: 11/21/18 Foley Cath Care Every Shift...Change Foley Bag Weekly...Change Foley Catheter 16FR 30ML Balloon as needed...Ensure Foley leg strap/cath secure in place to prevent tension on Foley...Order Date: 02/12/19 Change Foley Catheter 16FR 30ML balloon Q [every] month..." Resident #12's CCP (comprehensive care plan) included: "ADL (activities of daily living)/Incontinence/Skin...Monitor skin integrity during personal care and notify nurse/MD of any impairements (sic)...Provide foley cath care every shift. Ensure foley leg strap is on with cath secured to prevent tension on foley. Empty cath bag as neede. (sic) Change cath bag weekly. Ensure cath bag is placed below level of bladder. Do not allow cath bag to touch floor. Change foley catheter monthly and as needed per current MD order..." The Administrator and DON were informed of the above findings during a meeting with the survey team on 02/14/2019 at 12:10 p.m. The DON (director of nursing) was interviewed at 12:40	F 657		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 657	Continued From page 6 p.m. regarding care plan updates. The DON stated, "The MDS Coordinators update care plans from looking at the nurse's notes, the 24-hour report and physician orders. A copy of the 24-hour report and physician orders are put in her box each day." No further information was received by the survey team prior to the exit conference on 02/14/2019.	F 657		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.	F 690	**F690** **Corrective Action(s):** Resident #29's physician was notified that the facility failed to assess, treat and provide appropriate interventions related to urethral erosion from long term Foley Catheter use and that the facility failed to discuss treatment options with the responsible party related to the possible placement of a Supra Pubic catheter. A facility incident and accident form was completed for this incident. Resident #12's physician was notified that the facility failed to assess, treat and provide appropriate interventions related to urethral erosion from long term Foley Catheter use and that the facility failed to discuss treatment options with the responsible party related to the possible placement of a Supra Pubic catheter. A facility incident and accident form was completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a Foley catheter may have been potentially affected. The DON, ADON and or QA Nurse will conduct a 100% review of all residents with a Foley catheter to identify residents at risk. Residents identified will be	3/18/19

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F 690	Continued From page 7 §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure two of 17 residents were assessed and provided appropriate care and treatment/services for the identification of complications related to the prolonged use of an indwelling catheter. 1. Facility staff failed to assess, treat, and provide appropriate interventions related to the prolonged use of an indwelling catheter for Resident #29. Resident #29 was identified by the urologist as having urethral erosion from the prolonged use of an indwelling catheter and recommended the resident undergo a procedure for a suprapubic catheter. There was no documentation in the clinical record that the recommendations had been discussed with the responsible party, nor was there any evidence of the facility's ongoing assessment of the area. Resident #29 had severe urethral trauma which was identified as harm. 2. Facility staff failed to assess and provide appropriate services to identify complications related to the use of an indwelling catheter. Findings were:	F 690	corrected at time of discovery and a Facility Incident & Accident Form will be completed. **Systemic Change(s):** The facility Policy and Procedure for Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be inserviced by the DON on the policy and procedures for proper Foley Catheter care to include the proper anchoring of Foley catheter tubing, proper placement of the drainage bag to prevent infection and injury, weekly assessment and documentation of the Catheter insertion site to monitor for urethral erosion and trauma. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON, ADON and/or QA nurse will make daily random audits of all Foley Catheter's to ensure compliance with anchoring of tubing and proper placement of drainage bags to monitor compliance. All negative findings will be corrected at time of discovery and disciplinary action taken as warranted. The QA nurse will review the weekly skin assessments to monitor for urethral erosion and trauma to the meatus. All negative findings will be reported to the attending physician for proper care and treatment and the resident comprehensive plan of care updated to reflect current treatment interventions. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: March 18, 2019**	

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F 690	Continued From page 8 1. Resident #29 was admitted to the facility on 06/20/2016 with the following diagnoses, but not limited to: Respiratory failure, Parkinson's disease, dysphagia, Type II diabetes mellitus, urinary retention, benign prostatic hyperplasia, and hypertension. The quarterly MDS (minimum data set) with an ARD (assessment reference date) of 01/07/2019, assessed Resident #29 as severely impaired in his cognitive status with a summary score of "06". On 02/12/2019 at approximately 12:15 p.m., Resident #29 was observed sitting in his wheelchair at a table in the dining room. His catheter bag was attached to the top of his wheelchair back, at shoulder level. The catheter tubing was observed coming out of his left pants leg, under the wheelchair, and up the back of the chair to the drainage bag. There was no urine in the tubing. At approximately 3:45 p.m., Resident #29 was observed sitting in his wheelchair in the hallway. His catheter bag was in the same position. The tubing under the chair was filled with bright red fluid. A CNA (certified nursing assistant) came down the hallway and invited Resident #29 to an activity in the dining room. She wheeled him down the hall, she did not reposition the bag. The DON (director of nursing) was in her office with the ADON (assistant director of nursing) and the MDS nurse, LPN (licensed practical nurse) #2. A copy of the facility policy regarding catheters was requested from DON. She was asked about the placement of catheter bags. She stated, "Below the level of the bladder." The observation in the hallway was discussed. The	F 690		

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F 690	Continued From page 9 ADON and LPN #2 left the office.. At approximately 4:00 p.m., this surveyor went to the dining room; Resident #29 was no longer in the activity. Resident #29 had been taken to his room by the ADON and LPN #2. The DON came down the hall and entered the room with this surveyor. Resident #29 was lying on his bed, his brief was partially off. The catheter tubing had been emptied. The catheter bag was hanging on the top side rail, at mid chest level. Resident #29 was not circumcised, the foreskin of his penis was retracted by LPN #2. She stated, "He has a split here on the underside of his penis. Resident #29's penis was split from the head down shaft; the catheter was not inserted in his penis at all but directly into the scrotal area. There was fresh blood around head of penis. The catheter tubing was not anchored. The ADON was asked why the catheter was not anchored. She stated, "The doctor doesn't want his catheter anchored...we have an order not to....the family didn't want a suprapubic catheter but they have now agreed." The clinical record was reviewed, and there were no orders to not anchor the Foley catheter. The skin assessments were reviewed. There was no mention on the skin assessments of Resident #29's penis. The DON was asked if there was any documentation regarding the family's refusal of the suprapubic catheter or where anyone had spoken to them. She stated, "I'll see what I can find." At 4:30 p.m., the wound nurse went to Resident #29's room to measure the open area on his penis. She was asked if she had measured the area in the past. She stated, "No, this is the first time I have looked at him." The area measured,	F 690		

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F 690	Continued From page 10 5.5 cm long and 1 cm wide. The wound nurse stated, "I've never seen anything like this...I'm not sure what to do." The catheter tubing was still not anchored. The tubing went out of his brief, down his pants leg, and up to the catheter bag, still hanging at mid chest level. The wound nurse was asked if there was tension on the tubing. She stated, "Yes", and moved the catheter bag down on the bed frame. Resident #29 stated, "That's enough, that's enough, it's sore." The facility policy "Catheter Care, Urinary" was reviewed and contained the following information: "The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder...Ensure that the catheter remains secured with a leg strap to reduce friction and movement at the insertion site if resident will allow and is able to tolerate...The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine such as color ...clarity...and odor. 5. Any problems noted at the catheter-urethral junction during perineal care such as drainage, redness, bleeding, irritation, crusting, or pain. 6. Any problems or complaints made by the resident related to the procedure. 7. How the resident tolerated the procedure. 8. If the resident refused the procedure, the reason(s) why and the intervention taken. 9. The signature and title of the person recording the data." On 02/13/2019 the clinical record was reviewed for further information. The POS (physician order	F 690		

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F 690	Continued From page 11 sheet) for January 2019 contained the following: "Foley care q [every] shift; Flush Foley twice weekly; Change 16 [french] Foley catheter with 30 cc balloon monthly per urology." The nurse's notes were reviewed from 08/01/2018 - 02/13/2019. There was no documentation as outlined in the facility policy regarding assessments, problems with the catheter site, interventions, etc., during any of the catheter changes or when catheter care was provided each shift. The urology notes were reviewed and contained the following: "01/04/2018 Recurrent UTI's, Chronic urinary retention, Acquired hypospadial urethral erosion...recommendations: I will discuss with [physician name] re: SPT [suprapubic catheter] vs continued Foley..." "08/13/2018 Chronic urinary retention...urethral erosion. Recommendations: Change Foley catheter every 4 weeks, *Flush Foley at least twice a week, strongly consider suprapubic catheter if patient can be medically cleared." There was no documentation in the clinical record from either the nursing staff of the primary physician that the need for a suprapubic catheter was discussed with the family. On 02/13/2019 at approximately 2:00 p.m., the DON and the wound nurse came to the conference room to discuss Resident #29. The DON stated, "I can't find very much in the record...here's a note from April 2017, one form November 2017 and one from April 2018....that's	F 690		

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F 690	Continued From page 12 it." The notes contained the following: "04/26/2017 While looking at RSD (resident) penis for cath care, I observed some tearing and a small mount of blood on the underside of the penis at the urethral opening. I contacted MD...he ordered a consult to urology..." "11/3/2017 Resident went to ER ...due to pulling at Foley. Resident transferred himself to the bathroom without assistance...Resident states... he accidentally sat on his cath. The head of resident's penis is torn and resident is having some bloody drainage..." The DON was asked if there was any follow-up documentation or measurements of the areas described in the notes. She stated, "No, this has been a slow ongoing thing with him...when he came back from the urologist in August [2018] the nurse wrote an order to change the catheter every 4 weeks, because we were changing it weekly per the family's request, she wrote to consider suprapubic catheter placement after he was medically cleared...I asked her if she discussed that with the family and she doesn't remember...there aren't any notes in the record from [name of Resident #29's physician] about it." The DON was asked since it was a slow ongoing thing wouldn't that be all the more reason to be documenting the measurements/appearance of the area in the clinical record. She nodded her head, indicating "Yes." The wound nurse stated, "I called his sister last night...he [Resident #29] was trying to get out of the bed, kicking off his covers, pulling at his catheter...she said that she knew he had pulled it out twice in the past...she said he just doesn't realize he is hurting	F 690		

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F 690	Continued From page 13 himself..." The wound nurse stated, "He does pull at his catheter sometimes." The DON was asked if there was any place in the record other than on the TAR (treatment administration record) where nurse's documented catheter care or changing of the catheter. She stated, "No." She was asked where the documentation outlined in the facility policy regarding care of the Foley catheter would be documented. She stated, "It isn't." The care plan was reviewed, the focus area: "ADL/Incontinence/Skin...Foley cath in place d/t [due to] urinary retention/obstructive uropathy", had the following interventions: Provide Foley cath care. Keep cath bag below level of bladder and empty bag as needed throughout the shift. Do not allow cath bag to touch the floor....1/29: Urethral tear has worsened..." An additional focus area: "Catheter/UTI [Urinary Tract Infection] risk...has urethral tear from Foley cath [no date this was added]; 1/29: Urethral tear from Foley has worsened. Urology consult for suprapubic cath scheduled...Interventions included: Change Foley per current MD order; Monitor for s/sx [signs and symptoms] of UTI..., change catheter drainage bag weekly; cue/remind resident as needed of importance of keeping drainage bag below bladder to decrease the risk of infection; Monitor Foley insertion site for s/sx of trauma/infection, i.e. redness, purulent drainage, pain, etc and report to nurse/MD; Provide Foley cath care. Keep cath bag below level of bladder and empty as needed throughout the shift. Do not allow cath bag to touch floor; Assist resident with proper placement of catheter drainage bag below level of bladder; Flush Foley per current MD order."	F 690		

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F 690	Continued From page 14 The DON and the wound nurse were informed that there were no interventions on the care plan, nor had there been any documentation observed in the clinical record regarding Resident #29 pulling at his Foley catheter. On 02/14/2019 at approximately 8:50 a.m., the Corporate Medical Director came to the conference room to speak with the survey team. He stated that he had examined Resident #29 for the first time the previous evening. He stated that penile/urethral erosion was very common in elderly due to long term catheter usage. He stated that in his opinion, the facility's lack of documentation and assessment was not the issue, but the failure was that the urologist had not provided appropriate interventions and that the facility needed to get a second opinion from another urologist. He stated that he did not think the facility had caused the resident harm and what he saw was not an acute problem. The Corporate Medical Director was referred to a nurse's note written on 02/10/2019 which contained information that Resident #29 had >100,000 mixed bacterial flora in his urinalysis and the culture and sensitivity was pending. He was asked if he felt the placement of the catheter bag, well above the level of the bladder would contribute to a urinary tract infection, He stated, "No, the contributing factor to his UTI's is the placement of the catheter, not the position of the bag." The Corporate Medical Director's was reviewed at approximately 9:45 a.m. The note contained the following: "This is an 84 year old patient that is a long term resident of the facility that has had a Foley catheter for about 2 years and has had multiple follow-ups with the urologist. On	F 690		

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F 690	Continued From page 15	F 690		

assessment, the patient has no acute pathology/swelling/evidence of trauma/evidence of Foley catheter irritation or allergy to the tubing of the Foley catheter....the presentation of the patient's penis/urethral meatus on todays [sic] visit is similar in appearance that was present during the urological visit and furthermore, the presence of the urethral meatus separation is a common problem in the geriatric population from long standing Foley cath use..."

At 10:10 a.m., the urologist that had examined Resident #29 was contacted via telephone. A message was left with his office staff asking him to call this surveyor regarding Resident #29. The urologist did not return the call.

During and end of the day meeting on 02/14/2019 at approximately 12:15 p.m., with the DON and the administrator the above information was discussed. The DON was asked if the primary care physician had submitted any information regarding the progression of Resident #29's urethral erosion. She stated, "Not yet." The DON and the administrator were informed that the facility's failure to assess and document changes in the erosion of Resident #29's penis were identified as harm by the survey team.

At approximately 12:45 p.m., the DON presented a note that had been faxed to the facility from the primary care physician regarding Resident #29. Information included: "Asked by staff to comment on [name of Resident #29] chronic Foley catheter. He was last seen by urology around August 2018 and option for suprapubic catheter was raised. Apparently, his sister was not in favor of that because of her fear of the risks of surgery and he had been through a lot of issues

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F 690	Continued From page 16 with his pacemaker right before that. Last fall I was encouraging his sister to move his care to a palliative only direction (Hospice, for example) but she was not in favor of that at the time. He has frequent UTIs and intermittent pain in that area (usually with UTIs). As all patients with Foley catheters in that long, he has erosion and enlargement of his urethra now...." The DON was asked if the primary care physician had discussed the suprapubic catheter with the family in August. She stated, "I don't know, it's not in the note." No further information was obtained prior to the exit conference on 02/14/019. 2. Resident #12 was originally admitted to the facility on 12/31/2013 and readmitted on 11/21/2018 with diagnoses including, but not limited to: Obstructive and reflux uropathy, Benign prostatic hyperplasia, Retention of urine and Diabetes Mellitus Type 2. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) 10/01/2018. Resident #12 was assessed as severely impaired in his cognitive status with a total cognitive score of four out of 15. On 02/12/2019 at 9:49 a.m., Resident #12 was observed sitting in his wheelchair (w/c) at the end of a hallway with his eyes closed. His Foley catheter bag was observed hanging from the handles on the back of his wheelchair. The level of his drainage bag was above his waist. Urine observed in the tubing was cloudy, yellow with white sediment.	F 690		

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F 690	Continued From page 17 Resident #12 was observed at 3:44 p.m. in activities with his catheter drainage bag hanging from the handles on the back of his wheelchair. The DON (director of nursing) was interviewed at 3:50 p.m. regarding placement of Resident #12's drainage bag. The DON stated, "I don't know why they are doing that now. We were making sure the bags were below the chair, but not dragging the floor. Those bags [referring to privacy bags] have straps long enough to hang the drainage bags low." On 02/13/2019 at 8:00 a.m. LPN #1 (licensed practical nurse), wound care nurse, and this surveyor assessed Resident #12's penis and Foley catheter. Resident #12's urinary meatus was split from the opening of his penis to the start of his penile shaft. Catheter tubing was secured to his right thigh and the drainage bag was hanging on the right side of the bed, below the bladder. Resident #12 denied pain from the catheter. Resident #12's clinical record was reviewed on 02/13/2019 at approximately 8:30 a.m. During this review urology visit notes included the following documentation: 03/08/2018 - "...he has had foley several months and has penile erosion. Urethral erosion. Foley in several months, with erosion ventrally up 50% of shaft. Consideration for sp [suprapubic] tube is made..." 06/21/2018 - "...Urinary Retention & Penile Erosion...Significant erosion...I do not feel SP tube is indicated now..." 09/27/2018 - "...No change in penile erosion..."	F 690		

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F 690	Continued From page 18 12/13/2018 - "...Penile erosion stable. Cont [continue] monthly tube change. Continue to affix to leg. Watch device & ensure tube/foley is not kinked..." 01/17/2019 - "...He had gross hematuria and went to ER [emergency room]...Change Foley per routine. We might consider imaging if this recurs." Subsequent review of physician progress notes at the facility dated 06/15/2018, 08/14/2018, 09/18/2018, 10/09/2018, 11/27/2018, and 01/22/2019 did not include any documentation of Resident #12's penile erosion or mention of any of his urology visits. The current POS (physician order sheet) dated February 2019 included the following orders: "...Order Date: 11/21/18 Foley Cath Care Every Shift...Change Foley Bag Weekly...Change Foley Catheter 16FR 30ML Balloon as needed...Ensure Foley leg strap/cath secure in place to prevent tension on Foley...Order Date: 02/12/19 Change Foley Catheter 16FR 30ML balloon Q [every] month..." Resident #12's CCP (comprehensive care plan) included: "ADL (activities of daily living)/Incontinence/Skin...Monitor skin integrity during personal care and notify nurse/MD of any impairements (sic)...Provide foley cath care every shift. Ensure foley leg strap is on with cath secured to prevent tension on foley. Empty cath bag as neede. (sic) Change cath bag weekly. Ensure cath bag is placed below level of bladder. Do not allow cath bag to touch floor. Change foley catheter monthly and as needed per current	F 690		

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F 690	Continued From page 19 MD order..." Resident #12's son was interviewed via phone on 02/13/2019 at 11:24 a.m. The son stated, "We have had issues since he had the catheter placed. He was retaining urine and unable to empty his bladder. He has had several infections and problems with getting the catheter replaced. He sees a urologist that changes his catheter. I was not aware that he has a split from the catheter. The urologist mentioned a suprapubic catheter once when he first started seeing them, but not recently. The doctor really doesn't like them." The DON and LPN #1 were interviewed on 02/13/2019 at 3:20 p.m. regarding Resident #12's penile erosion. LPN #1 stated, "I do skin checks, but I don't always look at penises, so I guess that's on me. I did not know his penis was split until yesterday. No, I have not measured the area." The DON stated, "I didn't know either. We identified a problem with assessments and documentation on the first of February and have been inservicing the staff." LPN #1 came to the conference room at approximately 3:45 p.m. and stated the eroded area (split) area on Resident #12's penis measured 3cm x 0.5cm (centimeters). The only mention of Resident #12's penile erosion in nursing notes was in a note dated 02/01/2019 at 9:45 p.m. and a note dated 02/09/2019 at 1:28 a.m., both written by the same LPN. Both notes stated, "...Foley cath intact and patent draining clear yellow urine without difficulty...Penile head remains split..." These notes had corresponding skin assessments. No	F 690		

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F 690	Continued From page 20 other skin assessments were located in the record. On 02/14/2019 at approximately 8:30 a.m. the DON and Corporate Medical Director approached the conference room and asked to speak to the survey team. He stated he had assessed Resident #12 and had written a note. He concluded with stating, "His penile erosion is a chronic problem without current acute symptoms. This is very common in elderly males with long term catheter use. He has been seen by the urologist several times and also has been to the hospital for catheter issues. I cannot argue that the documentation sucks and that another urologist should have been consulted, but I do not feel the facility has caused harm." The Corporate Medical Director's clinical note dated 02/13/2019 included: "...long term resident of the facility that has had a foley catheter for over 2 years and has had multiple follow ups with the urologist. On assessment the patient has no acute pathology/swelling/evidence of trauma/evidence of foley catheter irritation or allergy to the tubing of the foley catheter. He was last seen by the urologist on 03/08/2018, 12/12/18, and 01/17/2019. The current status of the urethral meatus separation had been present on these last several visits with no urological intervention recommendation except for recommendation that the patients foley not get kinked. The presentation of the patients Penis/urethral meatus on todays visit is the similar appearance that was present during the urological visit and furthermore, the presence of the urethral meatus separation is a common problem in the geriatric population from long standing foley cath use..." The Corporate	F 690		

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F 690	Continued From page 21 Medical Director stated this was the only time he had ever seen and assessed Resident #12. Several attempts were made on 02/14/2019 at 10:30 a.m. to contact Resident #12's urologist. The phone always rang busy. Facility policy, "Catheter Care, Urinary" included the following documentation: "Maintaining Unobstructed Urine Flow...3. The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder...Changing Catheters...14. Assess the urethral meatus...18. Secure catheter utilizing a leg band. 19. Check drainage tubing and bag to insure (sic) that the catheter is draining properly...Documentation - The following information should be recorded in the resident's medical record: 1. The date and time that catheter care was given. 2. The name and title of the individual(s) giving the catheter care. 3. All assessment data obtained when giving catheter care. 4. Character of urine..." The Administrator was informed of the above findings during a meeting with the survey team on 02/14/2019 at 12:10 p.m. No further information was received by the survey team prior to the exit conference on 02/14/2019.	F 690		
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	F 695	**F 695** **Corrective Action(s):** Resident #48's attending physician was notified that resident #48 did not receive humidified oxygen at the correct flow rate as ordered by the physician. A facility Incident & Accident form has been completed for this incident.	3/18/19

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F 695	Continued From page 22 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, resident interview, staff interview, facility document review, and clinical record review, facility staff failed to ensure proper administration of oxygen for one of 17 residents in the survey sample, Resident #48. Facility staff failed to ensure Resident #48's oxygen was humidified per physician order. Findings included: Resident #48 was admitted to the facility on 11/20/2018 with diagnoses including, but not limited to: Gastrointestinal hemorrhage, Morbid obesity, Mitral valve prolapse and Atrial fibrillation. The most recent MDS (minimum data set) was a quarterly assessment with an ARD (assessment reference date) of 12/14/2018. Resident #48 was assessed as cognitively intact with a total cognitive score of 12 out of 15. Resident #48 was observed on 02/12/2019 at 9:20 a.m. in her room, sitting up in her wheelchair (w/c). She had O2 at 3L/min/nc (3 liters per minute by nasal cannula) in place. There was a humidifier bottle connected to the oxygen concentrator that was completely empty. Resident #48 stated regarding her oxygen, "I think it is supposed to be on two liters. Yes, it should be humidified because it dries my nose out."	F 695	**Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all residents receiving oxygen will be conducted by the DON, ADON and/or QA Nurse to identify residents at risk for not having oxygen administered per MD order and proper maintenance of humidifier bottles for oxygen delivery. 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 administration has been reviewed and no changes were warranted at this time. 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, monitoring of oxygen flow rates during shift, monitoring Humidifier bottles during shift and the proper storage of oxygen/nebulizer equipment when not in use. **Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or QA Nurse will perform daily 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: March 18, 2019**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495321	A. BUILDING _____ B. WING _____	02/14/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL LEXINGTON	205 HOUSTON STREET EAST LEXINGTON, VA 24450

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F 695	Continued From page 23 On 02/13/2019 at 8:05 a.m. Resident #48 was observed in her room. Her oxygen was on 2L/min/nc and her humidifier bottle was completely empty. At 8:15 a.m., RN #1 (registered nurse) was interviewed regarding Resident #48's oxygen and humidifier bottle. RN #1 stated, "No, I didn't notice. I haven't given her her breathing treatment yet this morning. I will take care of it." Resident #48's clinical record was reviewed on 02/13/2019 at 10:00 a.m. The POS (physician order sheet) dated February 2019 included: "...O2@2lpm via NC with humidification..." The CCP (comprehensive care plan) included: "...Cardiac/Respiratory...Provide oxygen per current MD order/standing orders as indicated..." The "Oxygen Administration" policy was requested and received on 02/13/2019 at 3:00 p.m. Included in the policy, "Purpose: The purpose of this procedure is to provide guidelines for safe oxygen administration...Steps in the Procedure: ...12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened...14. Periodically re-check water level in humidifying jar (if used)..." The Administrator and DON (director of nursing) were informed of the above findings during a meeting with the survey team on 02/14/2019 at 12:10 p.m. The DON stated, "It is everybody's responsibility, the CNA's [certified nursing assistants], the nurses, medical records because she changes out the oxygen tubing every week, she is also a CNA, to check the humidifier	F 695		

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F 695	Continued From page 24 bottles." No further information was received by the survey team prior to the exit conference on 02/14/2019.	F 695		
F 880 SS=F	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	F 880	**F880** **Corrective Action(s):** The medical director was notified that the facility failed to develop and/or implement a water management program for the prevention of Legionella or other waterborne pathogens. NALCO; the contracted water management consultant for the facility has developed a detailed risk assessment that is required as part of our water management program for the facility. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have potentially been affected. A complete review of the facility water management plan was completed by the facility and NALCO. The Maintenance Director was in-serviced on the plan and his responsibility to ensure compliance to the water management program. Any negative finding will be corrected at time of discovery and a facility Incident & Accident form will be completed. **Systemic Change(s):** The facility Water Management Program has been reviewed and all missing documentation and discrepancies have been corrected. The Maintenance Director and Administrator will review and be in-serviced by the Regional Facility Advisor on the facility's water management program to include, the facility risk	3/18/19

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F 880	Continued From page 25 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, 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 develop a water management program for the prevention of legionella or other waterborne pathogens.	F 880	assessment, water mapping diagram and the requirements for visual inspections, cleaning and testing within the facility. **Monitoring:** The Maintenance Director is responsible for maintaining compliance. The facility Water Management program will be reviewed quarterly by the Maintenance director at the Quality Assurance Committee meeting for review, analysis, and recommendations for change in the facility water management program. **Compliance Date: March 18, 2019**	

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F 880	Continued From page 26 Findings include: On 02/14/19 at approximately 10:00 AM, the legionella information was reviewed. The information did not include a facility risk assessment, did not include a mapping diagram, or information regarding visual inspections, cleaning and testing within the facility. The administrator was asked for assistance with the above information. A policy on legionella was presented and documented, "...testing protocols and acceptable ranges (control limits) will be established for each control measure...testing and visual inspections will be documented...all visual inspections, cleaning, and water testing will be documented..." At approximately 11:30 AM, the maintenance director was interviewed regarding the above information. The maintenance director stated that the mapping diagram was for another facility and was for presentation only and stated he would provide one for this facility. The maintenance director then stated that they only have to test annually. The maintenance director stated that he had not done a facility map, had not done visual inspections, cleaning or testing and that there was no documentation for that. At approximately 11:45 AM, the maintenance director presented a mapping diagram for the facility water system. No other information or documentation was presented to evidence that an effective water management program was developed and implemented. No further information and/or documentation was presented prior to the exit conference on	F 880		

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F 880	Continued From page 27 02/14/18.	F 880		

State of Virginia

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F 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 02/12/2019 through 02/14/2019. Corrections are required for compliance with the Rules and Regulations for the Licensure of Nursing Facilities. The census in this 60 certified bed facility was 54 at the time of the survey. The survey sample consisted of 14 current record reviews and three closed record reviews.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tim Lawrence | TITLE: Administrator | (X6) DATE: 3/1/19