State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0102	A. BUILDING: _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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) COMPLETE DATE
F 000	Initial Comments An unannounced Medicare/Medicaid standard survey and biennial State Licensure Inspection was conducted 03/19/19 through 03/21/19. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not it compliance with the following Virginia Rules and Regulations for Licensure of Nursing Facilities. Resident Rights 12 VAC 5-371-150 (A, B, C)- cross reference to F550 and F565 Nursing Services 12 VAC 5-371-220 (H)-cross reference to F580 Policies and Procedure 12 VAC 5-371-140 (D)-cross reference to F622, F623, F625 Nurse Staffing 12 VAC 5-371-210 (A.2)-cross reference to F658 Nursing Services	F 001	**F 001** **Resident Rights** **12 VAC 5-371-150 (A, B, C)** – Cross References to F550 and F565 Cross Reference to POC for F550 and F565 **Nursing Services** **12 VAC 5-371-220 H** - Cross Reference to F580 Cross Reference to POC for F580 **Policies and Procedure** **12 VAC 5-371-140 (D)** - Cross Reference to F622, F623, F625 Cross Reference to POC for F622, F623, F625 **Nurse Staffing** **12 VAC 5-371-210 (A.2)** - Cross Reference to F658 Cross Reference to POC for F658	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jerrick B. Ratliff — TITLE: Administrator — (X6) DATE: 4/22/19

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F 001	Continued From page 1 12 VAC 5-371-220-cross reference to F684, F695, F759 Pharmaceutical Services 12 VAC 5-371-300 (A)-cross reference to F761 Clinical Records 12 VAC 5-371-360-cross reference to F842 Infection Control 12 VAC 5-371-180-cross reference to F880 Maintenance and Housekeeping 12 VAC 5-371-370 (B)-cross reference to F584 and F921 Laundry Services 12 VAC 5-371-380-cross reference to F880	F 001	**Nursing Services** **12 VAC 5-371-220** Cross Reference to F684, F695, F759 Cross Reference to POC for F684, F695, F759 **Pharmaceutical Services** **12 VAC 371-300 (A)** - Cross Reference to F761 Cross Reference to POC for F761 **Clinical Records** **12 VAC 371-360** - Cross Reference to F842 Cross Reference to POC for F842 **Infection Control** **12 VAC 371-180** - Cross Reference to F880 Cross Reference to POC for F880 **Maintenance and Housekeeping** **12 VAC 371-370 (B)** - Cross Reference to F584 and F921 Cross Reference to POC for F584, F921 **Laundry Services** **12 VAC 371-380** Cross Reference to F880 Cross Reference to POC for F880 **Completion Date: 5/5/19**	

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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/19/2019 through 03/21/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 03/19/19 through 03/21/19. 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 120 certified bed facility was 112 at the time of the survey. The survey sample consisted of 23 current Resident reviews and 3 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:** The facility has identified an alternate location for Resident Council to meet to ensure that privacy is maintained during their meetings. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have potentially been affected. The Activities director will review the Resident Council Minutes for the previous 90 days to identify residents with concerns or complaints about privacy not being maintained during the resident council meeting. Any/all concerns noted will be reviewed with the administrator for any corrective action that may be needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Derrick B. Kirby | TITLE: Administrator | (X6) DATE: 4/22/19

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 resident council interview, staff interview, and facility document review, the facility staff failed to ensure a private location for the resident council to meet. Volunteers and residents interrupted the resident council meeting on three (3) different occasions. The findings included: Volunteers and residents not attending the resident council meeting interrupted the meeting on multiple occasions.	F 550	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All staff will be inserviced by the Social Services Director and/or Activities Director on Resident Rights and Dignity to include the proper procedure to be maintained during all Resident Council meetings A staff member has been asked to attend the resident council meeting to supervise and ensure that resident privacy and dignity are maintained during the meeting. **Monitoring:** The Administrator is responsible for compliance. The Administrator and/or Activities Director will monitor the Resident Council Meeting to ensure that staff maintain the privacy and dignity of the meeting area. Any/all negative findings will be corrected immediately, and disciplinary action will be taken as warranted. Aggregate findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in policy, procedure, and/or facility practice. **Completion Date: 5/5/19**	

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

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F 550	Continued From page 2 On 3/20/19 at 11:00 a.m., the surveyor met with a group of the facility residents. Seven residents attended the resident council meeting. The assistant activity director placed signs on both entrances to the dining room at 11:07 a.m. Immediately after placing the signs on the door and before the activity assistant left the room, two residents came through the main dining room entrance, walked to the end of the room, and went to the outside deck area. At 11:11 a.m., a resident entered the resident council meeting from the rehab side entrance, pedaled the wheelchair through the dining room and exited the main entrance to the dining room with the help of a second resident who opened the door for the resident to let out. At 11:32 a.m., a third resident entered from the outside rehab entrance and walked to the area where crafts were set up. At 11:48 a.m., a volunteer entered the dining room from the main entrance. The volunteer came in, walked to the kitchen door, took the resident sitting in the Geri chair out through the main entrance door, then came back, and apologized for coming in. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern in the end of the day meeting on 3/20/19 at 5:40 p.m. No further information was provided prior to the exit conference.	F 550		
F 565	Resident/Family Group and Response	F 565	**F565** **Corrective Action(s):**	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 565 SS=C	Continued From page 3 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident council interview, staff	F 565	The Activity Director and the Activity Assistant have received inservice training on the requirement that all grievances&concerns must be acted upon promptly by the facility when the issues are resident care and quality of life related. **Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Activity Director will meet with the Resident Council and review theResident Rights Policy regarding Grievances & Concerns and the process to be followed. **Systemic Change(s);** Facility policy and procedure was reviewed and no changes are warranted at this time. The Activity Director will review the Resident Grievance & Concerns policy with all Department Head Staff to ensure they are aware of the grievance & Concern policy and the requirement that all grievances & Concerns related to their specific departments will be acted upon promptly and returned to the Activity Director for review with the administrator and the resident(s). **Monitoring:** The Activity Director is responsible for maintaining compliance. The Activity Director will review resident council minutes monthly and the grievance log weekly to monitor for any resident concerns not acted upon. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date: 5/5/19**	

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F 565	Continued From page 4 interview, and facility document review, the facility staff failed to act upon grievances/concerns from the December 2018 resident council meeting. The findings included: The surveyor obtained the resident council minutes from December 2018, January 2019 and February 2019 during the entrance conference on 3/19/19 from the administrator. The resident council president was identified as Resident #58. On 3/20/19 at 11:00 a.m., the surveyor met with a group of the facility residents. Part of the interview included review of the previous three months resident council minutes and discussion of the minutes with the group. Seven residents attended the resident council meeting. Issues from the December 2018 resident council meeting minutes were as follows: one resident wanted her clothing rack lowered. The barrels are loud. One resident wanted another lift and wanted different food and one resident wanted the closet neater. The surveyor asked the group if the concerns identified in the resident council minutes were addressed and followed up with the group. Resident #58 stated the facility doesn't act promptly on concerns. Resident #58 stated, "The group tells me and we discuss it and we bring it up at the next meeting. The barrels/trash cans are still an issue. They wake you up at night. That's a joke. They wake everybody up at night." The minutes reflected that in December 2018 both the activity director and the assistant activity director attended the resident council meeting.	F 565		

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F 565	Continued From page 5 The January 2019 resident council minutes reviewed. The surveyor did not find any documentation of the follow-up from the December 2018 meeting. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern in the end of the day meeting on 3/20/19 at 5:40 p.m. The administrator stated the activity staff fill out the concern form and take it to the dept and then take it to the adminstrator for signature. The administrator informed the surveyor on 3/21/19 at 7:15 a.m. that the concern with the noise from the barrels had been addressed and new barrels had been ordered. The administrator asked if the surveyor had received the department response forms. The surveyor had not. The administrator provided the surveyor with the responses from the identified concerns from the December 2018 meeting and stated the department involved was given the concern form and then gives the response what was done to correct the concern. The issue concerning the loudness of the barrels was never addressed the administrator stated. No further information was provided prior to the exit conference on 3/21/19.	F 565		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident	F 580	**F580** **Corrective Action(s)** Resident #160's representative was notified that facility failed to notify them when an antibiotic was ordered to treat a UTI by the nurse practitioner. A Facility Incident & Accident form has been completed for this incident.	

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F 580	Continued From page 6 representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement	F 580	**Identification of Deficient Practices & Corrective Action(s):** All other residents with physician ordered antibiotic orders may have potentially been affected. The DON, ADON and or Unit Managerwill complete a 100% review of all resident physician orders, to identify all antibiotics ordered to identify resident at risk. All negative findings will be corrected at the time of discovery and the Resident Representatives will be notified. A facility Incident & Accident form has been completed for this incident. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The 24 Hour Report serves as the source document for communicating changes in condition, status, proper notification to the attending physicians and the responsible parties and revision/updates to the comprehensive plan of care. The 24 Hour Report will be reviewed and initialed daily by the Administrator, DON and Unit Manager.The Licensed staff will be inserviced by the DON and/or Regional nurse consultant on the Notification of Rights & Services and issued a copy of the facility policy and procedure. The inservice will include staff education on Physician and RP notification for any changein resident status, medications, treatments.	

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F 580	Continued From page 7 its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to inform the resident representative of a change in condition for 1 of 26 residents (Resident #160). The findings included: The facility staff failed to inform Resident #160's responsible party of a new order for an antibiotic. The clinical record of Resident #160 was reviewed 3/21/19. Resident #160 was admitted to the facility 12/18/18 and readmitted 1/7/19 with diagnoses that included but not limited to cerebral infarction, hemiplegia following cerebral infarction affecting left non-dominant side, ST elevation, cardiomegaly, hypertension, dysphagia, hyperlipidemia, anxiety, obstructive and reflux uropathy, acute upper respiratory infection, and embolism and thrombosis of arteries of lower extremities. Resident #160's 30 day minimum data set (MDS) with an assessment reference date (ARD) of 2/5/19 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills for decision making-decisions poor; needs cues and supervision. Resident #160 had orders dated 1/10/19 for a UA	F 580	**Monitoring:** The DON and Unit Managers are responsible for maintaining compliance. Daily audits of physician orders will be completed to identify residents with physician ordered antibiotics to monitor compliance. All Any/all negative findings will be corrected at time of discovery and appropriate disciplinary action taken. Aggregate findings will be reported to the QA Committee for review, analysis and recommendation for changes in facility policy, procedure and/or practice. **Completion Date: 5/5/19**	

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F 580	Continued From page 8 (urinalysis) w (with) culture/sensitivity dx (diagnosis) hematuria. The surveyor located two results of the urine culture-one found in Resident #160's clinical record and one found in Resident #46's clinical record. The results found in Resident #46's record had an order written by the nurse practitioner (NP) for Cipro 500 mg (milligrams) q12 (every) 12 x 5 days and was dated 1-14-19. The culture result found in Resident #160's laboratory section read "No new orders-NP signature and dated 1-15-18 (?19)." The surveyor reviewed the 1/14/19 through 1/15/19 departmental notes and found no documentation the resident's responsible party was informed of the medication order. The surveyor informed the director of nursing of the above concern on 3/21/19 at 10:19 a.m. The surveyor requested the facility policy on change of condition/notification on 3/21/19. Asked if staff are responsible for notifying the resident's representative about medication changes, the director of nursing stated yes. The policy titled "Change in a Resident's Condition or Status" read in part "4. Unless otherwise instructed by the resident, a nurse will notify the resident's representative when b. There is a significant change in the resident's physical, mental, or psychosocial status." No further information was provided prior to the exit conference on 3/21/19.	F 580		
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584	**F584** **Corrective Action(s):** The Linen Barrels used to transport soiled linen in the facility that were very noisy have been replaced.	

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F 584 SS=C	Continued From page 9 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have potentially been affected. A complete documented environmental walkthrough of the facility will be conducted by the administrator and environmental services director to identify resident areas that have potential noise concerns related to the use of cleaning and transport equipment. All resident areas identified with potential noise concerns from cleaning and transport equipment will be immediately reviewed for corrections to control noise levels. **Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director and/or Environmental Director will provide inservices to all staff on facility policy and procedure on the notification system to use when repairs are needed throughout the facility to eliminate or correct problems with cleaning and transport equipment that are causing noise concerns in the resident care area. The maintenance request logs will be reviewed by the administrator weekly for completion of repairs.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 584	Continued From page 10 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, resident council interview, staff interview, and facility document review, the facility staff failed to ensure a comfortable sound level in the building. The findings included: The facility staff failed to maintain a comfortable sound level. Trash cans/barrels were noisy when the staff rolled them up and down the halls on each of the units collecting trash and soiled linens. During the survey, four surveyors interviewed residents on both units. The noise made from the barrels was noticeable often-interrupting conversation because the surveyor could not hear what the resident was saying. The surveyor interviewed Resident #79 on 3/19/19 at 11:44 a.m. Resident #79 was asked during the interview how the noise in the facility was and the resident stated, "The barrels are loud when rolling down the hall." Resident #79 was interviewed in the resident room with the door closed; however, noise from the barrels was still heard. The surveyor obtained the resident council minutes from December 2018, January 2019 and February 2019 during the entrance conference on 3/19/19 from the administrator. The resident council president was identified as Resident #58. On 3/20/19 at 11:00 a.m., the surveyor met with a group of the facility residents. Part of the	F 584	**Monitoring:** The Environmental Director and the Maintenance Director is responsible for maintaining compliance. Documented facility rounds will be completed weekly to monitor compliance. The administrator will review weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date: 5/5/19**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 584	Continued From page 11	F 584		

interview included a review of the previous three months resident council minutes and discussion of the minutes with the group. Seven residents attended the resident council meeting.

One issue from the December 2018 resident council meeting minutes was the loudness of the barrels.

The surveyor asked the group if the concerns identified in the resident council minutes were addressed and followed up with the group. Resident #58 stated the facility doesn't act promptly on concerns. Resident #58 stated, "The group tells me and we discuss it and we bring it up at the next meeting. The barrels/trash cans are still an issue. They wake you up at night. That's a joke. They wake everybody up at night."

The minutes reflected that in December 2018 both the activity director and the assistant activity director attended the resident council meeting.

The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern in the end of the day meeting on 3/20/19 at 5:40 p.m.

The administrator informed the surveyor on 3/21/19 at 7:15 a.m. that the concern with the noise from the barrels had been addressed and new barrels had been ordered. The surveyor asked the administrator how concerns were addressed from the resident council. The administrator asked if the surveyor had received the department response form. The surveyor had not. The administrator provided the surveyor with the responses from the identified concerns from the December 2018 meeting and stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 584	Continued From page 12 department involved was given the concern form and then given the response. The issue concerning the loudness of the barrels was never addressed, the administrator stated. No further information was provided prior to the exit conference on 3/21/19.	F 584		
F 622 SS=E	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;	F 622	**F622** **Corrective Action(s):** The facility staff failed to provide the receiving Hospital with the appropriate information related to the resident transfer. The facility did not send contact information for the attending physician,contact information for the Resident Representative, Advance directive information, instructions for ongoing care, comprehensive care plan goals and discharge summary. The facility also failed to document the information provided to the receiving hospitalfor Residents #2, #44, #46, #72 and #110. 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/designeewill 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.	

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	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 622	Continued From page 13 or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 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	F 622	**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 facilitylicensed staff and social services 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. **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: 5/5/19**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 622	Continued From page 14 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 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, facility document review and clinical record review, the facility staff failed to provide the receiving provider with information that included the contact information of the practitioner responsible for the care of the resident, Resident representative information including contact information, Advance Directive information, all special instructions or precautions for ongoing care, as appropriate, comprehensive care plan goals, and 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 for 5 of 26 residents (Resident #2, Resident #44, Resident #46, Resident #72, and Resident #110). The findings included: 1. The facility staff failed to provide the receiving	F 622		

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	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 622	Continued From page 15	F 622		

provider information for care of Resident #2-the name of the practitioner at the nursing home, the resident representative contact information, advanced directive information, instructions for ongoing care, the comprehensive care plan goals, and the discharge summary. The facility staff failed to document in the clinical record what information was provided to the receiving provider for Resident #2.

The clinical record of Resident #2 was reviewed 3/19/19 through 3/21/19. Resident #2 was admitted to the facility 10/11/12 and readmitted 2/26/19. Diagnoses included but not limited to acute cellulitis right foot with infected ulceration of right great toe, probable peripheral vascular disease, diabetes mellitus type II, atrial fibrillation, esophageal reflux, hypertension, dysphagia, convulsions, anxiety, dementia without behavioral disturbances, hyperlipidemia, anemia, Alzheimer's disease, and seizure disorder.

Resident #2's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/11/18 assessed the resident with short-term memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making.

The departmental note dated 2/26/19 at 2:34 p.m. read "LE (late entry) from 0900: Rescue 33 here to transport res (resident) to (name of hospital omitted). Informed by night shift nurse that MD (medical doctor) wants res (resident) sent to (name of hospital omitted) for direct admit due to cellulitis of Rt. (right) leg. Called for transport and hospital was notified."__

The surveyor was unable to locate information

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 622	Continued From page 16 sent to the receiving provider from the facility. The surveyor spoke with the corporate registered nurse on 3/20/19 at 10:24 a.m. what information was sent to the hospital when residents are transferred. The corporate RN stated the social worker completes that. The surveyor interviewed the social worker. The social worker was asked what information was sent with the resident when the resident was admitted to the hospital on 2/26/19. The social worker provided the surveyor a form titled "Heritage Hall Grundy Discharge/Transfer Form." The form read, "I understand that I am being discharged from Heritage Hall Grundy. I understand that the reason for the transfer is recommendation of physician for direct admission to hospital. Resident in (name of hospital omitted) 2/27/19. Copy mailed to RP (responsible party) on 2/28/19." The social worker stated he provided no information to the hospital when Resident #2 was transferred 2/26/19. Bed hold acceptance/declination located at the bottom of the page was blank. The corporate RN informed the surveyor 3/20/19 at 10:30 a.m. a transfer/discharge report was not done. The surveyor requested the facility policy on transfers/discharges. The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged	F 622		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 622	Continued From page 17 d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above information on 3/21/19. No further information was provided prior to the exit conference on 3/21/19. 2. The facility staff failed to provide the receiving provider with contact information of the practitioner caring for the resident, the resident representative contact information, advanced directive information, any special instructions for ongoing care, the comprehensive care plan goals and a copy of the discharge summary and failed to document what information was provided to the receiving provider for Resident #44. The clinical record of Resident #44 was reviewed 3/19/19 through 3/21/19. Resident #44 was admitted to the facility 9/23/09, readmitted 11/29/16 and 1/5/19 with diagnoses that included but not limited to hemiplegia following cerebral infarction affecting left non-dominant side, hepatomegaly, dysphagia, gastro-esophageal reflux disease, arthopathy, diabetic ketoacidosis with new onset type 1 diabetes, sepsis due to multifocal pneumonia, acute renal failure secondary to volume depletion, hypertension,	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 622	Continued From page 18 hyperlipidemia, urinary tract infection with methicillin sensitive Staph aureus, hyponatremia, and history of seizure disorder. Resident #44's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/3/19 assessed the resident with a brief interview for mental status as 15/15. The clinical record revealed a departmental note dated 12/31/18 that read in part Resident #44 vomited a large amount of brown substance. Call to nurse practitioner who ordered the resident to be transferred to the hospital. The order dated 12/31/18 read "Transfer to ____ (name of hospital) ER (emergency room) for eval (evaluation) of congestion, N/V (nausea/vomiting) x 2 days. BP (blood pressure) 130/76, T (temperature) 97.7, P (pulse) 110, 94%." The surveyor was unable to locate documentation in the clinical record of information provided to the receiving provider when Resident #44 was transferred to the emergency room. The surveyor interviewed the director of nursing on 3/21/19 at 11:29 a.m. of the above concern when Resident #44 was transferred to the emergency room. The surveyor requested Resident #44's face sheet, MDS, care plan, December 2018 departmental notes, January 2019 departmental notes and the facility policy for transfer/discharges. The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge	F 622		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 622	Continued From page 19 b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; No further information was provided prior to the exit conference on 3/21/19. 3. The facility staff failed to provide the receiving provider information for care of Resident #46-the name of the practitioner at the nursing home, the resident representative contact information, advanced directive information, instructions for ongoing care, the comprehensive care plan goals, and the discharge summary. The facility staff failed to document in the clinical record what information was provided to the receiving provider for Resident #46. The clinical record of Resident #46 was reviewed 3/19/19 through 3/21/19. Resident #46 was admitted to the facility 6/27/17 and readmitted 9/21/07 with diagnoses that included non-displaced fracture of lateral malleolus right fibula, non-traumatic subdural hemorrhage, constipation, gastroesophageal reflux disease, hypertension, Vitamin deficiency, convulsions, benign prostatic hyperplasia, diabetes mellitus type 2, chronic hepatitis, dry eye syndrome, and anemia.	F 622		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 622	Continued From page 20 Resident #46's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The surveyor interviewed Resident #46 on 3/20/19. When asked if the resident had any falls, Resident #46 raised his right leg, pointed to his ankle, and stated he slipped in the snow and broke his ankle. The surveyor reviewed the departmental note dated 1/24/19 at 12:00 p.m. The note read "LE (late entry) from 0900: Res (resident) came walkin (sic) down hall to nurse and stated "I was walking outside and slipped and hurt my ankle but I'm okay. Assessment reveals swollen area to RT (right) ankle. Instructed res to elevate leg and FNP (family nurse practitioner) was notified and gave order for x-ray. Instructed rest to not be outside walking due to inclement weather. FNP notified and res is own RP (responsible party)." The 1/24/19 6:06 p.m. departmental note read "Late entry for 1700 (5:00 p.m.) FNP notified of x-rays and gave orders to send resident to ER (emergency room) for further eval (evaluation). @ (at) 1712 (5:12 p.m.) Rescue 33 ambulance services here @ this time to transport resident to (name of hospital ER) omitted. ER staff given report. Resident clean and dry upon departure and no visible signs of distress noted." The surveyor was unable to locate documentation in the clinical record of information sent to the hospital when Resident #46 was transferred there on 1/24/19.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 622	Continued From page 21 The surveyor informed the corporate registered nurse of the above concern on 3/20/19 at 2:01 p.m. and asked where the information was located when the resident was sent to the emergency room. The corporate RN stated the transfer forms had not been started yet. The surveyor requested the facility policy on transfers/discharges. The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; No further information was provided prior to the exit conference on 3/21/19. 4. The facility staff failed to provide the receiving provider information for care of Resident #72-the name of the practitioner at the nursing home, the resident representative contact information, advanced directive information, instructions for ongoing care, the comprehensive care plan goals, and the discharge summary. The facility	F 622		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 622	Continued From page 22 staff failed to document in the clinical record what information was provided to the receiving provider for Resident #72. The clinical record of Resident #72 was reviewed 3/19/19 through 3/21/19. Resident #72 was admitted to the facility 3/8/16 and readmitted 9/24/18 with diagnoses that included but not limited to above the knee amputation, acute diastolic heart failure, chronic obstructive pulmonary disease, insomnia, psoriasis, gastro-esophageal reflux disease, hypothyroidism, Vitamin deficiency, anemia, muscle weakness, obesity, hypertension, varicose veins of left lower extremity, type 2 diabetes mellitus, and mononeuropathy. Resident #72's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/25/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The clinical record revealed a discharge summary dated 9/24/18. The surveyor reviewed the departmental notes for September 2018. The departmental note dated 9/20/18 at 8:23 a.m. read "Upon administering res (resident) am (morning) medication, res lethargic, opens eyes a few times and goes back to sleep. O2 (oxygen) 86%. V/S (vital signs): BP (blood pressure) 157/105, P (pulse) 86, R (respirations) 20, T (temperature) 98.5. Edema noted to face/eyes and hands. Notified FNP (family nurse practitioner). Stated to send res to (name of hospital emergency room omitted) for eval (evaluation). Called 911. Upon arrival of Rescue 33, res nonresponsive. Res LOA (leave of absent) to hospital at 0525, res clean and dry	F 622		

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

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F 622	Continued From page 23 upon departure. Notified ER and gave report given. Res is own RP (responsible person). Attempted to notify 2nd contact without success. Notified niece-she stated her mother is out of town for a few days, to contact her if needed anything." The departmental note dated 9/20/18 at 9:58 a.m. read "Resident admitted to hospital ICU (intensive care unit) with dx (diagnosis) of acute hypoxemia and resp (respiratory) distress." The surveyor was unable to locate transfer/discharge form or documentation of pertinent information sent with Resident #72 when transported to the hospital on 9/20/18. The surveyor informed the administrator, director of nursing, and the corporate registered nurse of the above concern on 3/20/19 at 4:18 p.m. The surveyor requested the face sheet, MDS, care plan, September progress notes and the policy for transfers/discharges. The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and	F 622		

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F 622	Continued From page 24 (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; No further information was provided prior to the exit conference on 3/21/19. 5. The facility staff failed to provide the hospital with the required paper work concerning Resident #110's medical information. Resident #110 was admitted to the facility on 2/6/19 with the following diagnoses of, but not limited to anemia, heart failure, high blood pressure, pneumonia and dementia. On the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/9/19, the resident was coded as having short term and long-term memory problems and being moderately impaired in daily decision-making. Resident #110 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing. During the closed record review on 3/20/18, the surveyor noted that Resident #110 had been transferred to the hospital on 2/9/19. The surveyor could not find any documentation that the facility provided to the hospital concerning the resident's medical condition and/or list of medications. Since the resident expired at the hospital on 2/9/19, the facility was not required to offer the bed hold policy in writing to the resident's representative. The director of nursing and social worker was notified of the above documented findings on 3/20/19 at 3:55 pm. The social worker stated, "We didn't send any paperwork with the resident to the hospital when he was transferred."	F 622		

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	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 622	Continued From page 25 No further information was provided to the surveyor prior to the exit conference on 3/21/19.	F 622		
F 623 SS=E	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 #2's responsible party has been notified that the facility failed to provide a discharge/transfer notice, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such to the resident and the Responsible party for the resident's transfer to the hospital on 2/26/19 and the facility failed to document in the medical record the Ombudsman notification of the discharge. Resident #44's responsible party has been notified that the facility failed to provide a discharge/transfer notice, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such to the resident and the Responsible party for the resident's transfer to the hospital on 12/31/18 and the facility failed to document in the medical record the Ombudsman notification of the discharge Resident #46's responsible party has been notified that the facility failed to provide a discharge/transfer notice,failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of suchto the resident and the Responsible party for the resident's transfer to the hospital on 1/24/19 and the facility failed to document in the medical record the Ombudsman notification of the discharge.	

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F 623	Continued From page 26 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	F 623	Resident #72's responsible party has been notified that the facility failed to provide a discharge/transfer notice,failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such to the resident and the Responsible party for the resident's transfer to the hospital on 9/20/18 and the facility failed to document in the medical record the Ombudsman notification of the discharge. **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 30 days. Residents identified at risk will be corrected at time of discoveryand 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 willinservice the facility's social worker(s), nursing administration and licensed staff on the discharge and transfer requirements that are to be given to the resident and resident's responsible party and that the state ombudsman will be notified of resident discharges/transfers.	

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F 623	Continued From page 27 advocacy of individuals with a mental disorder established under the Protection and Advocacy 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, facility document review and clinical record review, the facility staff failed to provide written notice of transfer/discharge to include the effective date of transfer or discharge; the location to which the resident is transferred or discharged; 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; the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman and documentation in the medical record that the notice was sent to the Ombudsman for 4 of 26	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: 5/5/19**	

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

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F 623	Continued From page 28 residents (Resident #2, Resident #44, Resident #46, and Resident #72). The findings included: 1. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #2 was transferred to the hospital. The clinical record of Resident #2 was reviewed 3/19/19 through 3/21/19. Resident #2 was admitted to the facility 10/11/12 and readmitted 2/26/19. Diagnoses included but not limited to acute cellulitis right foot with infected ulceration of right great toe, probable peripheral vascular disease, diabetes mellitus type II, atrial fibrillation, esophageal reflux, hypertension, dysphagia, convulsions, anxiety, dementia without behavioral disturbances, hyperlipidemia, anemia, Alzheimer's disease, and seizure disorder. Resident #2's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/11/18 assessed the resident with short-term memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making. The departmental note dated 2/26/19 at 2:34 p.m. read "LE (late entry) from 0900: Rescue 33 here to transport res (resident) to (name of hospital omitted). Informed by night shift nurse that MD	F 623		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 623	Continued From page 29 (medical doctor) wants res (resident) sent to (name of hospital omitted) for direct admit due to cellulitis of Rt. (right) leg. Called for transport and hospital was notified." The surveyor was unable to locate the above information in Resident #2's clinical record. The surveyor spoke with the corporate registered nurse on 3/20/19 at 10:24 a.m. what information was sent to the hospital when residents are transferred. The corporate RN stated the social worker completes that. The surveyor interviewed the social worker. The social worker was asked what information was sent with the resident when the resident was admitted to the hospital on 2/26/19. The social worker provided the surveyor a form titled Heritage Hall Grundy Discharge/Transfer Form." The form read, "I understand that I am being discharged from Heritage Hall Grundy. I understand that the reason for the transfer is recommendation of physician for direct admission to hospital. "Resident in (name of hospital omitted) 2/27/19. Copy mailed to RP (responsible party) on 2/28/19." The social worker stated he provided no information to the hospital when Resident #2 was transferred 2/26/19. Bed hold acceptance/declination located at the bottom of the page was blank. The corporate RN informed the surveyor 3/20/19 at 10:30 a.m. a transfer/discharge report was not done. The surveyor requested the facility policy on transfers/discharges. The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or	F 623		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 30 resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above information on 3/21/19. No further information was provided prior to the exit conference on 3/21/19. 2. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #44 was transferred to the hospital. The clinical record of Resident #44 was reviewed 3/19/19 through 3/21/19. Resident #44 was admitted to the facility 9/23/09, readmitted 11/29/16 and 1/5/19 with diagnoses that included	F 623		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 31 but not limited to hemiplegia following cerebral infarction affecting left non-dominant side, hepatomegaly, dysphagia, gastro-esophageal reflux disease, arthopathy, diabetic ketoacidosis with new onset type 1 diabetes, sepsis due to multifocal pneumonia, acute renal failure secondary to volume depletion, hypertension, hyperlipidemia, urinary tract infection with methicillin sensitive Staph aureus, hyponatremia, and history of seizure disorder. Resident #44's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/3/19 assessed the resident with a brief interview for mental status as 15/15. The clinical record revealed a departmental note dated 12/31/18 that read in part resident #44 vomited a large amount of brown substance. Call to nurse practitioner who ordered the resident to be transferred to the hospital. The order dated 12/31/18 read "Transfer to ____ (name of hospital) ER (emergency room) for eval (evaluation) of congestion, N/V (nausea/vomiting) x 2 days. BP (blood pressure) 130/76, T (temperature) 97.7, P (pulse) 110, 94%." The surveyor was unable to locate documentation in the clinical record of the above information when Resident #44 was transferred to the emergency room. The surveyor interviewed the director of nursing on 3/21/19 at 11:29 a.m. of the above concern when Resident #44 was transferred to the emergency room. The surveyor requested Resident #44's face sheet, MDS, care plan, December 2018 departmental notes, January departmental notes and the facility policy for	F 623		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 32 transfer/discharges. The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; No further information was provided prior to the exit conference on 3/21/19. 3. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #46 was transferred to the hospital. The clinical record of Resident #46 was reviewed 3/19/19 through 3/21/19. Resident #46 was admitted to the facility 6/27/17 and readmitted 9/21/07 with diagnoses that included	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 33	F 623		

non-displaced fracture of lateral malleolus right fibula, non-traumatic subdural hemorrhage, constipation, gastroesophageal reflux disease, hypertension, Vitamin deficiency, convulsions, benign prostatic hyperplasia, diabetes mellitus type 2, chronic hepatitis, dry eye syndrome, and anemia.

Resident #46's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

The surveyor interviewed Resident #46 on 3/20/19. When asked if the resident had any falls, Resident #46 raised his right leg, pointed to his ankle, and stated he slipped in the snow and broke his ankle.

The surveyor reviewed the departmental note dated 1/24/19 at 12:00 p.m. The note read "LE (late entry) from 0900: Res (resident) came walkin (sic) down hall to nurse and stated "I was walking outside and slipped and hurt my ankle but I'm okay." Assessment reveals swollen area to RT (right) ankle. Instructed res to elevate leg and FNP (family nurse practitioner) was notified and gave order for x-ray. Instructed rest to not be outside walking due to inclement weather. FNP notified and res is own RP (responsible party)."

The 1/24/19 6:06 p.m. departmental note read "Late entry for 1700 (5:00 p.m.) FNP notified of x-rays and gave orders to send resident to ER (emergency room) for further eval (evaluation). @ (at0 1712 (5:12 p.m.) Rescue 33 ambulance services here @ this time to transport resident to (name of hospital ER) omitted. ER staff given

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 623	Continued From page 34 report. Resident clean and dry upon departure and no visible signs of distress noted." The surveyor was unable to locate documentation in the clinical record of the above information when Resident #46 was transferred there on 1/24/19. The surveyor informed the corporate registered nurse of the above concern on 3/20/19 at 2:01 p.m. and asked where the information was located when the resident was sent to the emergency room. The corporate RN stated the transfer forms had not been started yet. The surveyor requested the facility policy on transfers/discharges. The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information: a. The reason for the transfer or discharge b. The effective date of the transfer or discharge c. The location to which the information is being transferred or discharged d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; No further information was provided prior to the exit conference on 3/21/19.	F 623		

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F 623	Continued From page 35 4. The facility staff failed to provide written notice of transfer to the resident and the resident representative when the resident was transferred to the hospital, failed to provide a statement of the resident's appeal rights, failed to provide information on how to obtain an appeal form and assistance in completion of such and failed to document in the medical record ombudsman notification when Resident #72 was transferred to the hospital. The clinical record of Resident #72 was reviewed 3/19/19 through 3/21/19. Resident #72 was admitted to the facility 3/8/16 and readmitted 9/24/18 with diagnoses that included but not limited to above the knee amputation, acute diastolic heart failure, chronic obstructive pulmonary disease, insomnia, psoriasis, gastro-esophageal reflux disease, hypothyroidism, Vitamin deficiency, anemia, muscle weakness, obesity, hypertension, varicose veins of left lower extremity, type 2 diabetes mellitus, and mononeuropathy. Resident #72's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of2/25/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The clinical record revealed a discharge summary dated 9/24/18. The surveyor reviewed the departmental notes for September 2018. The departmental note dated 9/20/18 at 8:23 a.m. read "Upon administering res (resident) am (morning) medication, res lethargic, opens eyes a few times and goes back to sleep. O2 (oxygen) 86%. V/S (vital signs): BP (blood pressure) 157/105, P (pulse) 86, R (respirations) 20, T	F 623		

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F 623	Continued From page 36	F 623		

(temperature) 98.5. Edema noted to face/eyes and hands. Notified FNP (family nurse practitioner). Stated to send res to (name of hospital emergency room omitted) for eval (evaluation). Called 911. Upon arrival of Rescue 33, res nonresponsive. Res LOA (leave of absent) to hospital at 0525, res clean and dry upon departure. Notified ER and gave report given. Res is own RP (responsible person). Attempted to notify 2nd contact without success. Notified niece-she stated her mother is out of town for a few days, to contact her if needed anything."

The departmental note dated 9/20/18 at 9:58 a.m. read "Resident admitted to hospital ICU (intensive care unit) with dx (diagnosis) of acute hypoxemia and resp (respiratory) distress."

The surveyor was unable to locate transfer/discharge form or documentation of pertinent information when Resident #72 was transported to the hospital on 9/20/18.

The surveyor informed the administrator, director of nursing, and the corporate registered nurse of the above concern on 3/20/19 at 4:18 p.m. The surveyor requested the face sheet, MDS, care plan, September progress notes and the policy for transfers/discharges.

The facility policy titled "Transfer or Discharge Notice" read in part "3. The resident and/or resident representative (sponsor) will be notified in writing of the following information:
a. The reason for the transfer or discharge
b. The effective date of the transfer or discharge
c. The location to which the information is being transferred or discharged

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 623	Continued From page 37 d. A statement of the resident's rights to appeal the transfer or discharge, including; (1) the name, address, email and telephone number of the entity which receives such requests; (2) information about how to obtain, complete and submit an appeal form; and (3) how to get assistance completing the appeal process; e. The facility bed-hold policy; No further information was provided prior to the exit conference on 3/21/19.	F 623		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At	F 625	**F625** **Corrective Action(s):** Residents #2, #44, #46, #72, #86and their RP's have been notified of the facilities bed-hold policy and procedure and the requirement that it reviewed and issued in writing to the resident and the RP when discharge to the hospital or when going out on therapeutic leave. An Incident and Accident form has been completed for each resident identified in the review. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents could potentially be affected. The Bed-Hold policy and forms are now kept at the nursing station for after hour's transfers to the hospital to be completed by the charge nurse. The Social Services director/Admissions director will be responsible for normal business hour transfer notification of all bed-holds to residents and/or Responsible parties. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Social Services Director, Admissions Director and licensed staff have been inservicedby the administrator on the bed-hold	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 38 the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide to the resident and the resident representative at the time of transfer/discharge written notice which specifies the duration of the bed-hold policy for 5 of 26 residents (Resident #2, Resident #44, Resident #46, Resident #72, and Resident #86). The findings included: 1. The facility staff failed to provide Resident #2 and the resident representative written information about bed-hold when the resident was transferred to the hospital 2/26/19. The clinical record of Resident #2 was reviewed 3/19/19 through 3/21/19. Resident #2 was admitted to the facility 10/11/12 and readmitted 2/26/19. Diagnoses included but not limited to acute cellulitis right foot with infected ulceration of right great toe, probable peripheral vascular disease, diabetes mellitus type II, atrial fibrillation, esophageal reflux, hypertension, dysphagia, convulsions, anxiety, dementia without behavioral disturbances, hyperlipidemia, anemia, Alzheimer's disease, and seizure disorder. Resident #2's quarterly minimum data set (MDS) with an assessment reference date (ARD) of 12/11/18 assessed the resident with short-term	F 625	requirement and the proper use and notification of the Bed-Hold policy. **Monitoring:** The Admissions Director and Social Service Director are responsible for compliance. All transfers/discharges from the facility will be audited the by the Social service director and/or Admissions Director to ensure proper bed-hold notification was completed at the time of transfer or therapeutic leave. Any/all negative findings will be corrected at time of discovery. The results of these audits will be forwarded to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 5/5/19**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 39 memory problems, long-term memory problems, and severely impaired cognitive skills for daily decision-making. The departmental note dated 2/26/19 at 2:34 p.m. read "LE (late entry) from 0900: Rescue 33 here to transport res (resident) to (name of hospital omitted). Informed by night shift nurse that MD (medical doctor) wants res (resident) sent to (name of hospital omitted) for direct admit due to cellulitis of Rt. (right) leg. Called for transport and hospital was notified."__ The clinical record did not have documentation that written notice of bed hold information was provided to the resident and the resident representative when Resident #2 was transferred to the hospital 2/26/19. The surveyor spoke with the corporate registered nurse on 3/20/19 at 10:24 a.m. what information was sent to the hospital when residents are transferred. The corporate RN stated the social worker completes that. The surveyor interviewed the social worker. The social worker was asked what information was sent with the resident when the resident was admitted to the hospital on 2/26/19. The social worker provided the surveyor a form titled "Heritage Hall Grundy Discharge/Transfer Form." The form read, "I understand that I am being discharged from Heritage Hall Grundy. I understand that the reason for the transfer is recommendation of physician for direct admission to hospital. Resident in (name of hospital omitted) 2/27/19. Copy mailed to RP (responsible party) on 2/28/19." The social worker stated he provided no information to the hospital when Resident #2 was transferred 2/26/19.	F 625		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 40 Bed hold acceptance/declination located at the bottom of the page was blank. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 3/20/19 at 3:50 p.m. and requested the facility policy on bed hold. The surveyor reviewed the facility policy titled "Bed-Holds and Returns" on 3/21/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." No further information was provided prior to the exit conference on 3/21/19. 2. The facility staff failed to provide Resident #44 and the resident representative written information about bed-holds when the resident was transferred to the hospital 12/31/18. The clinical record of Resident #44 was reviewed 3/19/19 through 3/21/19. Resident #44 was admitted to the facility 9/23/09, readmitted 11/29/16 and 1/5/19 with diagnoses that included but not limited to hemiplegia following cerebral infarction affecting left non-dominant side, hepatomegaly, dysphagia, gastro-esophageal reflux disease, arthopathy, diabetic ketoacidosis with new onset type 1 diabetes, sepsis due to multifocal pneumonia, acute renal failure secondary to volume depletion, hypertension, hyperlipidemia, urinary tract infection with methicillin sensitive Staph aureus, hyponatremia, and history of seizure disorder.	F 625		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 41 Resident #44's 30-day minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/3/19 assessed the resident with a brief interview for mental status as 15/15. The clinical record revealed a departmental note dated 12/31/18 that read in part Resident #44 vomited a large amount of brown substance. Call to nurse practitioner who ordered the resident to be transferred to the hospital. The order dated 12/31/18 read "Transfer to ____ (name of hospital) ER (emergency room) for eval (evaluation) of congestion, N/V (nausea/vomiting) x 2 days. BP (blood pressure) 130/76, T (temperature) 97.7, P (pulse) 110, 94%." The clinical record did not have documentation that written notice of bed hold information was provided to the resident and the resident representative when Resident #44 was transferred to the hospital 12/31/18. The surveyor interviewed the director of nursing on 3/21/19 at 11:29 a.m. of the above concern when Resident #44 was transferred to the emergency room and admitted to the hospital. The surveyor requested Resident #44's face sheet, MDS, care plan, December 2018 departmental notes, January 2019 departmental notes and the bed hold policy. The surveyor reviewed the facility policy titled "Bed-Holds and Returns" on 3/21/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." No further information was provided prior to the exit conference on 3/21/19.	F 625		

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F 625	Continued From page 42 3. The facility staff failed to provide Resident #46 and the resident representative written information about bed-hold when the resident was transferred to the hospital 1/24/19. The clinical record of Resident #46 was reviewed 3/19/19 through 3/21/19. Resident #46 was admitted to the facility 6/27/17 and readmitted 9/21/07 with diagnoses that included non-displaced fracture of lateral malleolus right fibula, non-traumatic subdural hemorrhage, constipation, gastroesophageal reflux disease, hypertension, Vitamin deficiency, convulsions, benign prostatic hyperplasia, diabetes mellitus type 2, chronic hepatitis, dry eye syndrome, and anemia. Resident #46's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The surveyor interviewed Resident #46 on 3/20/19. When asked if the resident had any falls, Resident #46 raised his right leg, pointed to his ankle, and stated he slipped in the snow and broke his ankle. The surveyor reviewed the departmental note dated 1/24/19 at 12:00 p.m. The note read "LE (late entry) from 0900: Res (resident) came walkin (sic) down hall to nurse and stated "I was walking outside and slipped and hurt my ankle but I'm okay. Assessment reveals swollen area to RT (right) ankle. Instructed res to elevate leg and FNP (family nurse practitioner) was notified and gave order for x-ray. Instructed rest to not be	F 625		

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F 625	Continued From page 43 outside walking due to inclement weather. FNP notified and res is own RP (responsible party)." The 1/24/19 6:06 p.m. departmental note read "Late entry for 1700 (5:00 p.m.) FNP notified of x-rays and gave orders to send resident to ER (emergency room) for further eval (evaluation). @ (at) 1712 (5:12 p.m.) Rescue 33 ambulance services here @ this time to transport resident to (name of hospital ER) omitted. ER staff given report. Resident clean and dry upon departure and no visible signs of distress noted." The clinical record did not have documentation that written notice of bed hold information was provided to the resident and the resident representative when Resident #46 was transferred to the hospital 1/24/19. The surveyor informed the corporate registered nurse of the above concern on 3/20/19 at 2:01 p.m. and asked about bed-hold information. The corporate registered nurse stated the social worker completes that. The surveyor interviewed the social worker. The social worker did not have information about bed hold policy for Resident #46. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 3/20/19 at 3:50 p.m. and requested the bed hold policy. The surveyor reviewed the facility policy titled "Bed-Holds and Returns" on 3/21/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy."	F 625		

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F 625	Continued From page 44 No further information was provided prior to the exit conference on 3/21/19. 4. The facility staff failed to provide Resident #72 and the resident representative written information about bed-hold when the resident was transferred to the hospital 9/20/18. The clinical record of Resident #72 was reviewed 3/19/19 through 3/21/19. Resident #72 was admitted to the facility 3/8/16 and readmitted 9/24/18 with diagnoses that included but not limited to above the knee amputation, acute diastolic heart failure, chronic obstructive pulmonary disease, insomnia, psoriasis, gastro-esophageal reflux disease, hypothyroidism, Vitamin deficiency, anemia, muscle weakness, obesity, hypertension, varicose veins of left lower extremity, type 2 diabetes mellitus, and mononeuropathy. Resident #72's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/25/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The clinical record revealed a discharge summary dated 9/24/18. The surveyor reviewed the departmental notes for September 2018. The departmental note dated 9/20/18 at 8:23 a.m. read "Upon administering res (resident) am (morning) medication, res lethargic, opens eyes a few times and goes back to sleep. O2 (oxygen) 86%. V/S (vital signs): BP (blood pressure) 157/105, P (pulse) 86, R (respirations) 20, T (temperature) 98.5. Edema noted to face/eyes and hands. Notified FNP (family nurse	F 625		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 625	Continued From page 45 practitioner). Stated to send res to (name of hospital emergency room omitted) for eval (evaluation). Called 911. Upon arrival of Rescue 33, res nonresponsive. Res LOA (leave of absent) to hospital at 0525, res clean and dry upon departure. Notified ER and gave report given. Res is own RP (responsible person). Attempted to notify 2nd contact without success. Notified niece-she stated her mother is out of town for a few days, to contact her if needed anything." The departmental note dated 9/20/18 at 9:58 a.m. read "Resident admitted to hospital ICU (intensive care unit) with dx (diagnosis) of acute hypoxemia and resp (respiratory) distress." The clinical record did not have documentation that written notice of bed hold information was provided to the resident and the resident representative when Resident #72 was transferred to the hospital 9/20/18. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 3/20/19 at 3:50 p.m. and requested the bed hold policy. The surveyor reviewed the facility policy titled "Bed-Holds and Returns" on 3/21/19. The policy read in part "Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy." No further information was provided prior to the exit conference on 3/21/19. 5. The facility staff failed to provide the bed hold policy in writing due to Resident #86 being	F 625		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 625	Continued From page 46 transferred to emergency room. Resident #86 was originally admitted to the facility on 2/22/19 but was readmitted on 3/13/19. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 3/1/19, coded the resident as having a BIMS (Brief Interview for Mental Status) score of 12 out of a possible score of 15. Resident #86 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene and bathing. The surveyor reviewed Resident #86's clinical record on 3/20/19 and 3/21/19. During this review, the surveyor noted that Resident #86 had been transferred to the hospital, on 3/8/19, to receive a blood transfusion. The surveyor could not find documentation in the clinical record of the bed hold policy being given to the resident and/or resident representative in written form. The surveyor requested and received the policy titled "Transfer or Discharge Notice" which read in part, " ...The resident and/or representative (sponsor) will be notified in writing of the following information ...The facility bed hold policy ..." The surveyor notified the administrative team of the above documented findings on 3/20/19 at 3:55 pm in the conference room. On 3/21/19 at 9:06 am, the social worker came to the surveyor and stated, "We didn't give the resident the bed hold policy when he was transferred to the hospital." No further information was provided to the surveyor prior to the exit conference on 3/21/19.	F 625		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for the transcription of physician orders involving medications for 1 of 26 residents (Resident #160). The findings included: The facility staff incorrectly filed the results of Resident #160's laboratory test on Resident #46's clinical record. The laboratory test had physician orders for antibiotics for Resident #160. The physician orders were never implemented for Resident #160 because the facility staff filed the laboratory test results with orders in the wrong record. The 1/14/19 urine culture results had been noted by licensed practical nurse #1 (L.P.N. #1). L.P.N. #1 failed to write a telephone order for Resident #160's antibiotic. The clinical record of Resident #160 was reviewed 3/21/19. Resident #160 was admitted to the facility 12/18/18 and readmitted 1/7/19 with diagnoses that included but not limited to cerebral infarction, hemiplegia following cerebral infarction affecting left non-dominant side, ST elevation, cardiomegaly, hypertension, dysphagia, hyperlipidemia, anxiety, obstructive and reflux uropathy, acute upper respiratory infection, and	F 658	**F658** **Corrective Action(s):** Resident #160's attending physician has been notified that the facility staff did not implement an antibiotic order for resident # 160 as ordered by the physician because the facility filed the lab test results with the antibiotic order written on it in the wrong medical record. A Facility Incident&Accident Form was completed for these incidents **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON, ADON and/or designee will conduct a 100% review of all resident's medication orders and lab tetsts to identify any residents at risk. All residents identified at risk will be corrected at time of discovery and the attending physician will be notified of each error. An Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report, documentation in the medical record and physician orders remains the source document for the development and monitoring of care which includes, obtaining,transcribing and administering physician ordered medicationsper physician order.Licensed staff will be inserviced by the DON and/or regional nurse consultant on the policy & procedure for medication administration to include giving at ordered time and physician notification if a medication is held or refused.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 658	Continued From page 48 embolism and thrombosis of arteries of lower extremities. Resident #160's 30 day minimum data set (MDS) with an assessment reference date (ARD) of 2/5/19 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills for decision making-decisions poor; needs cues and supervision. Resident #160 had orders dated 1/10/19 for a UA (urinalysis) w (with) culture/sensitivity dx (diagnosis) hematuria. The surveyor located two results of the urine culture-one found in Resident #160's clinical record and one found in Resident #46's clinical record. The results found in Resident #46's record had an order written by the nurse practitioner (NP) for Cipro 500 mg (milligrams) q12 (every) x 5 days, dated 1-14-19 and noted by L.P.N. #1. The culture result found in Resident #160's laboratory section read "No new orders-NP signature and dated 1-15-18 (?19)." The surveyor was unable to locate a telephone order for the Cipro 500 mg q12 h x 5 days in Resident #160's clinical record. The surveyor informed the director of nursing of the above concern on 3/21/19 at 10:19 a.m. The surveyor requested the facility standard of practice for the transcription of physician orders and the policy on documentation. The DON was asked if the order found on the urine culture result should be transcribed to a telephone order	F 658	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will review medication orders weekly coinciding with the care plancalendar in order to maintain compliance. Any/all negative findings 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: 5/5/19**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 658	Continued From page 49 and the DON stated yes. The surveyor interviewed the family nurse practitioner (FNP) on 3/21/19 at 1:00 p.m. The FNP stated she was never made aware that Resident #160 did not receive the ordered antibiotic. "You assume the residents get the medications that I prescribe." The FNP was asked about the medication orders. After reviewing the lab results, the FNP stated she wanted the resident to have the Cipro. The facility policy titled "Medication and Treatment Orders" read, "1.Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 3. Drugs and biologicals must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. 4. All drugs and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order." The facility policy titled "Charting and Documentation" read in part "3. Documentation in the medical record will be objective, complete, and accurate." No further information was provided prior to the exit conference on 3/21/19.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684	**F684** **Corrective Action(s):** Resident #160's attending physician has been notified that the facility staff did not implement an antibiotic order for resident # 160 as ordered by the physician because the facility filed the lab test results with the antibiotic order written on it in the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 684	Continued From page 50 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: 2. The facility staff incorrectly filed the results of Resident #160's laboratory test on Resident #46's clinical record. The laboratory test had physician orders for antibiotics for Resident #160. The physician orders were never implemented for Resident #160 because the facility staff filed the laboratory test results with orders in the wrong record. The 1/14/19 urine culture results had been noted by licensed practical nurse #1 (L.P.N. #1). L.P.N. #1 failed to write a telephone order for Resident #160's antibiotic-Cipro 500 mg (milligrams) q (every) 12 hours x 5 days. Resident #160 did not receive Cipro for a urinary tract infection. The clinical record of Resident #160 was reviewed 3/21/19. Resident #160 was admitted to the facility 12/18/18 and readmitted 1/7/19 with diagnoses that included but not limited to urinary tract infection, cerebral infarction, hemiplegia following cerebral infarction affecting left non-dominant side, ST elevation, cardiomegaly, hypertension, dysphagia, hyperlipidemia, anxiety, obstructive and reflux uropathy, acute upper respiratory infection, and embolism and thrombosis of arteries of lower extremities. Resident #160's 30 day minimum data set (MDS) with an assessment reference date (ARD) of 2/5/19 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills for	F 684	wrong medical record. LPN#1 has received disciplinary action and has been inserviced by the DON/designee on physician order transcription. A Facility Incident&Accident Form was completed for these incidents. Resident #30's attending physician was notified that the facility staff failed to administer Atorvastatin and Coreg medicationsas ordered by the physician. A facility Medication Error form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have potentially been affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician medication orders and MAR's to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and no revisions are warranted at this time. The nursing assessment process as evidenced by the 24-Hour Report and documentation in the medical record /physician orders remains the source document for the development and monitoring of the provision of care, which includes, obtaining, transcribing and administering physician ordered medications and treatments. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 684	Continued From page 51 decision making-decisions poor; needs cues and supervision. Resident #160 had orders dated 1/10/19 for a UA (urinalysis) w (with) culture/sensitivity dx (diagnosis) hematuria. The surveyor located two results of the urine culture-one found in Resident #160's clinical record and one found in Resident #46's clinical record. The results found in Resident #46's record had an order written by the nurse practitioner (NP) for Cipro 500 mg (milligrams) q12 (every) x 5 days, dated 1-14-19 and noted by L.P.N. #1. The culture result found in Resident #160's laboratory section read "No new orders-NP signature and dated 1-15-18 (?19)." The surveyor was unable to locate a telephone order for the Cipro 500 mg q12 h x 5 days in Resident #160's clinical record. The surveyor informed the director of nursing of the above concern on 3/21/19 at 10:19 a.m. The surveyor requested the facility standard of practice for the transcription of physician orders and the policy on documentation. The DON was asked if the order found on the urine culture result should be transcribed to a telephone order and the DON stated yes. The surveyor interviewed the family nurse practitioner (FNP) on 3/21/19 at 1:00 p.m. The FNP stated she was never made aware that Resident #160 did not receive the ordered antibiotic. "You assume the residents get the medications that I prescribe." The FNP was	F 684	completing physician medication and treatment orders as ordered by the physician. Licensed staff will also be inserviced on the proper use of the facility emergency/Stat box for administering new or unavailable medications for administration. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly MAR and chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 5/5/19**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 684	Continued From page 52 asked about the medication orders. After reviewing the lab results, the FNP stated she wanted the resident to have the Cipro. The facility policy titled "Medication and Treatment Orders" read, "1. Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state. 3. Drugs and biologicals must be recorded on the Physician's Order Sheet in the resident's chart. Such orders are reviewed by the consultant pharmacist on a monthly basis. 4. All drugs and biological orders shall be written, dated, and signed by the person lawfully authorized to give such an order." The facility policy titled "Charting and Documentation" read in part "3. Documentation in the medical record will be objective, complete, and accurate." No further information was provided prior to the exit conference on 3/21/19. Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow physician orders for 2 of 26 Residents, Resident's #30 and #160. The findings included: 1. For Resident #30, the facility staff failed to administer the medications atorvastatin (liptor) and carvedilol (coreg) as ordered by the physician. The clinical record review revealed that Resident #30 had been re-admitted to the facility 12/28/18. Diagnoses included, but were not limited to, weakness, atrial fibrillation, hypertension, chronic	F 684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 684	Continued From page 53 obstructive pulmonary disease, hypothyroidism, and gastro-esophageal reflux disease. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/17/19 included a BIMS (brief interview for mental status) summary score of 11 out of a possible 15 points. A review of the Residents eMARs (electronic medication administration records) revealed that the facility nursing staff had documented that they had not administered the Residents atorvastatin 40 mg or the Residents carvedilol 3.125 mg on 03/01/19, as the medications were not available. A review of the facility stat box/emergency supply list revealed that the medications would have been available in the stat box/emergency supply for administration. The facility policy/procedure titled "Medication Shortages/Unavailable Medications" read in part, "Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy ...If the medication is not available in the Emergency Medication Supply, Facility staff should notify Pharmacy and arrange for an emergency delivery ..." The Residents CCP (comprehensive care plan) included the problem area at risk for complications related to hyperlipidemia approaches included, but were not limited to, medicate as ordered. The administrative staff were notified of the issue	F 684		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 684	Continued From page 54 regarding the Resident not receiving their physician ordered medications on 03/20/19 at 3:55 PM. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684		
F 695 SS=E	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: 2. For Resident #73 the facility staff failed to ensure respiratory equipment was bagged. Resident #73 was admitted to the facility on 09/27/17. Diagnoses included anemia, congestive heart failure, hypertension, diabetes mellitus and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/25/19 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #73's clinical record was reviewed on 03/20/19. It contained a signed physician's order summary, which read in part "Albuterol 2.5 mg/05 ml solution. Give 1 UD packet via nebulizer q	F 695	**F695** **Corrective Action(s):** Resident #73's attending physician was notified that the facility failed to store resident #73's Nebulizer mouth piece in a plastic bag when not in use. A facility Incident & Accident form has been completed for this incident. Resident #23's attending physician was notified that the facility failed to store resident #23'sBiPap mask and face gear in a plastic bag when not in use. Afacility Incident & Accident form has been completed for this incident. Resident #72's attending physician was notified that the facility failed to store resident #72'sBiPap mask, headgear and nebulizer mask in a plastic bag when not in use and the facility failed to administer oxygen at the physician ordered flow rate. Afacility Incident & Accident form has been completed for this incident. Resident #159's attending physician was notified that the facility failed to obtain BiPap settings and Oxygen flow rate from the physician and failed to store resident 159's BiPap mask and Nebulizer mask in a plastic bag when not in use and did not date oxygen tubing when changed.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 695	Continued From page 55 (every) 6 hrs" and "Ipratropium BR 0.02% solution. Take 1 UD packet via nebulizer q 6 hrs". On 03/20/19 at approximately 1300, surveyor observed Resident #73's nebulizer mouthpiece lying on his nightstand. The mouthpiece was not bagged. The surveyor spoke with the infection control nurse on 03/20/19 at approximately 1325 regarding Resident #73's nebulizer mouthpiece. The infection control nurse accompanied the surveyor to Resident's room. The infection control nurse observed the Resident's nebulizer mouthpiece and stated to the surveyor that the mouthpiece should not be lying on the nightstand, but should be bagged. The surveyor requested and was provided with a policy entitled "Departmental (Respiratory Therapy)-Prevention of Infection" which read in part "Infection Control Considerations related to Medication Nebulizers/Continuous Aerosol: 7. Store the circuit in plastic bag, marked with date and Resident's name, between uses". The concern of not having the Resident's nebulizer mouthpiece bagged was discussed with the administrative staff during a meeting on 03/20/19 at approximately 1555. No further information was provided prior to exit. 3. The facility staff failed to ensure Resident #23's bipap mask and headgear were stored in a plastic bag when not in use and failed to date when the oxygen tubing was changed. Resident #23's clinical record was reviewed 3/19/19 through 3/21/19. Resident #23 was	F 695	Resident #13's attending physician was notified that the facility failed to date resident #13's oxygen tubing when it was changed. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen, BiPap and nebulizer therapy may have potentially been affected. A 100% review of all residents receiving oxygen, using a BiPap and a nebulizers will be conducted by the DON, ADON and/or Unit Manager to identify residents at risk for not having oxygen administered per MD order, Not using BiPap per physician ordered settings and improper storage of oxygen/nebulizer equipment when not in use. Residents found to be at risk will be corrected at the time of discovery. A facility Incident& Accident form will be completed for each item discovered. **Systemic Change(s):** The facility policy and procedure for Oxygen administrationhas been reviewed and no changes were warranted at this time. All licensed nursing staff will be inserviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. Inservices will include the delivery of oxygen per physician order, applying and using the BiPap machine per physician ordered settings and monitoring of oxygen flow rates during shift and the proper storage of oxygen/nebulizer equipment when not in use.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 695	Continued From page 56 admitted to the facility 8/17/17 with diagnoses that included but not limited to cerebrovascular disease, dysphagia, hemiplegia following cerebral infarct affecting right non-dominant side, hypertension, major depressive disorder, hyperlipidemia, anxiety, gastroesophageal reflux disease, hypothyroidism, urine retention, dysarthria and anarthria, aphasia, chronic kidney disease, and unspecified intellectual disabilities. Resident #23's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 1/14/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #23's current comprehensive care plan was reviewed. Problem onset dated 1/18/19 read "Dx (diagnosis): SOB (shortness of breath). Approaches: Provide Bi-Pap as ordered." During the initial tour on 3/19/19 at 8:57 a.m., the surveyor observed a bipap mask and face gear lying on Resident #23's nightstand. Neither one were secured in a plastic bag. The oxygen concentrator in the room was turned off; however, the oxygen tubing was not dated. The surveyor interviewed licensed practical nurse #2 on 3/19/19 at 9:00 a.m. L.P.N. #2 was shown the mask and the oxygen tubing and stated the bipap mask should be in a bag. L.P.N. #2 stated oxygen tubing was supposed to be changed weekly and dated with a marker or with tape. The surveyor informed the corporate registered nurse of the above concern on 3/19/19 at 5:14 p.m. and requested the facility policy on storage of bipap masks and dating of oxygen tubing.	F 695	**Monitoring:** The DON is responsible for maintaining compliance. The DON, ADON and/or Unit manager will performdaily 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: 5/5/19**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 695	Continued From page 57 The facility policy titled "Departmental (Respiratory Therapy)-Prevention of Infection" read in part "Steps in the Procedure Infection Control Considerations Related to Oxygen Administration. 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannulae and tubing used prn (as needed) in a plastic bag when not in use. Steps in the Procedure Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol-7. Store the circuit in plastic bag, marked with date and resident's name, between uses." No further information was provided prior to the exit conference on 3/21/19. 4. The facility staff failed to ensure Resident #72's bipap mask, headgear, and nebulizer mask were stored in a plastic bag when not in use. The facility staff also failed to ensure Resident #72 received the physician ordered amount of oxygen. The clinical record of Resident #72 was reviewed 3/19/19 through 3/21/19. Resident #72 was admitted to the facility 3/8/16 and readmitted 9/24/18 with diagnoses that included but not limited to above the knee amputation, acute diastolic heart failure, chronic obstructive pulmonary disease, insomnia, psoriasis, gastro-esophageal reflux disease, hypothyroidism, Vitamin deficiency, anemia, muscle weakness, obesity, hypertension, varicose veins of left lower extremity, type 2 diabetes mellitus, and mononeuropathy. Resident #72's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/25/19 assessed the	F 695		

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F 695	Continued From page 58 resident with a BIMS (brief interview for mental status) as 15/15. Section O Special Treatments, Procedures and Programs was marked for oxygen use while a resident. Resident #72's current comprehensive care plan identified a problem with onset date of 3/1/19 that read resident was at risk for c/o (complaints of) SOB (shortness of breath) r/t (related to) dx (diagnosis): COPD (chronic obstructive pulmonary disease), has dx: allergies and dx: obstructive sleep apnea. Approaches: Provide O2 (oxygen) as ordered. The surveyor observed Resident #72 during the initial tour on 3/19/19 at 8:57 a.m. Resident #72 was observed sitting in his wheelchair with an oxygen canister attached to the wheelchair. The liter amount was turned to 3 liters. Resident #72 was in the process of being transported to an appointment and the emergency medical services staff were in attendance. The surveyor asked one of the members to read the oxygen amount and the EMS staff stated "3." Also during the initial tour, Resident #72 was observed to have bipap headgear and a facemask on the nightstand as well as a nebulizer machine with facemask. None were stored in a plastic bag. The nebulizer machine was covered with a towel. The surveyor informed licensed practical nurse #2 of the above and asked the nurse to come to Resident #72's room. L.P.N. #2 was shown the bipap machine and nebulizer and was asked if these were properly stored. L.P.N. #2 stated they needed to be in a plastic bag. L.P.N. #2 stated the facility only covers the nebulizer machines	F 695		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 59 with a towel. Resident #72's March 2019 physician's orders were reviewed. Orders read "Apply BIPAP QHS (at bedtime) with settings of 18/10 with rate of 20, Remove bipap (at 7:00 a.m.), O2 at 3 L/min (liters per minute) via nasal cannula, prn (as needed) dx: SOB (shortness of breath), and Albuterol sul (sulfate) 2.5mg/3ml (milliliter) soln (solution) Give 1 via neb (nebulizer) q (every) 8 hrs (hours) dx: SOB." The surveyor observed Resident #72 again on 3/19/19 at 4:01 p.m. Resident #72 was sitting in his wheelchair with oxygen at 2 liters/nc-not 3 liters as ordered. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concerns on 3/19/19 at 6:00 p.m. and again on 3/20/19 at 4:34 p.m. and requested the facility policy on oxygen/nebulizer care. The facility policy titled "Departmental (Respiratory Therapy)-Prevention of Infection" read in part "Steps in the Procedure Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol-7. Store the circuit in plastic bag, marked with date and resident's name, between uses." No further information was provided prior to the exit conference on 3/21/19. 5. The facility staff failed to obtain an order for the bipap settings and oxygen administration and failed to ensure Resident #159's bipap mask and nebulizer mask were stored in a plastic bag when	F 695		

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	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 695	Continued From page 60 not in use. Both were observed lying on the night stand during the resident interview on 3/19/19. The clinical record of Resident #159 was reviewed 3/19/19 through 3/21/19. Resident #159 was admitted 3/14/19 with diagnoses that included but not limited to severe bilateral chronic lymphedema, morbid obesity, obstructive sleep apnea, obstructive and reflux uropathy, hypertension, type 2 diabetes mellitus, hypothyroidism, hyperlipidemia, gastroesophageal reflux disease, and methicillin resistant staphylococcus aureus and MDRO (multi-drug resistant organism) to bilateral lower extremities. Resident #159 was on contact precautions. Resident #159's admission minimum data set (MDS) assessment had not yet been completed. The surveyor observed Resident #159 on 3/19/19 at 5:00 p.m. Resident #159 was observed in bed with oxygen concentrator at 2 liters via nasal cannula. O2 concentrator did not have a date on the tubing. Bipap mask was observed lying on the nightstand. The facemask was not secured in a plastic bag. The surveyor informed licensed practical nurse #2 of the above. The surveyor was unable to locate an order for the oxygen or the bipap settings for Resident #159. An order written 3/17/19 read to please call for settings on Bipap. The surveyor informed the administrator, the director of nursing and the corporate registered nurse of the above concern on 3/19/19 at 5:56 p.m.	F 695		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 61 The surveyor reviewed the facility policy for oxygen concentrators on 3/21/19. The facility policy titled "Departmental (Respiratory Therapy)-Prevention of Infection" read in part "Steps in the Procedure Infection Control Considerations Related to Oxygen Administration. 7. Change the oxygen cannulae and tubing every seven (7) days, or as needed. 8. Keep the oxygen cannulae and tubing used prn (as needed) in a plastic bag when not in use. Steps in the Procedure Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol-7. Store the circuit in plastic bag, marked with date and resident's name, between uses." No further information was provided prior to the exit conference on 3/21/19. Based on observation, staff interview, facility document review and clinical record review the facility staff failed to ensure respiratory equipment was stored properly and the oxygen tubing changed every 7 days for 5 of 26 residents in the survey sample (Resident #13, #73, #72, #159, and #23). The findings included: 1. The facility staff failed to date the oxygen tubing for Resident #13 when changed. Resident #13 was originally admitted to the facility on 12/27/18 and then readmitted to the facility on 3/12/19. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 1/3/19, the resident was coded as to having a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. Resident #13 was also coded as requiring extensive assistance of 2 staff members for dressing, personal hygiene	F 695		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 695	Continued From page 62 and bathing. During the initial tour of the facility on 3/19/19 at 10:15 am, the surveyor noted Resident #13 was wearing oxygen. Upon further investigation, the surveyor could not find a date on the oxygen tubing to indicate when it had been changed. On 3/20/19 at 10 am, the surveyor again observed the resident wearing oxygen but there was no date on the oxygen tubing to indicate when it had been changed. At 5:41 pm, the surveyor notified the administration team of the above documented findings. The surveyor requested a copy of the facility's policy in regards to the administration of oxygen. The director of nursing stated that the staff was to change the oxygen tubing once a week and when this done, they will mark the tubing with a date in a black sharpie pen. On 3/21/19 at 8 am, the director of nursing provided a copy of the policy titled "Departmental (Respiratory Therapy) Prevention of Infection. The policy read in part " ...Change the oxygen cannulae (sic) and tubing every (7) days, or as needed ..." No further information was provided to the surveyor prior to the exit conference on 3/21/19.	F 695		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater;	F 759	**F759** **Corrective Action(s):** Resident #29's attending physician was notified that resident #29 did not receive the correct dose of Sertraline during an observed medication pass. LPN #2 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was completed for each medication error.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 759	Continued From page 63 This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during a medication pass and pour observation, the facility staff failed to ensure a medication error rate of less than 5%. There were 2 errors in 25 opportunities for a medication error rate of 8%. These medication errors effected Resident #29 and #46. The findings included: 1. For Resident #29, the facility staff failed to administer the correct dosage of the Resident sertraline. The clinical record review revealed that Resident #29 had been re-admitted to the facility 04/11/18. Diagnoses included, but were not limited to, major depressive disorder, dementia, atrial fibrillation, peripheral vascular disease, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 01/15/19 included a BIMS (brief interview for mental status) summary score of 7 out of a possible 15 points. On 03/20/19 beginning at approximately 7:53 a.m., the surveyor observed LPN (licensed practical nurse) #2 prepare and administer Resident #29's morning medications. After placing the medication, sertraline 50 mg into the Residents medication cup LPN #2 handed the medication card to the surveyor for the surveyor to review. The surveyor then recorded the preprinted information on the medication card	F 759	Resident #46's attending physician was notified that resident #46 did not receive their Zantac as ordered by the physician during an observed medication pass. LPN #1 involved in the medication pass observation has received one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was completed for each medication error. **Identification of Deficient Practices & Corrective Actions(s):** All residents may have potentially been affected. A 100%medication pass audit of all licensed nurses within the facility will be conducted to identify those nurses at risk for Medication Administration and/or technique errors. A facility Incident& Accident form will be completed for each negative finding as well as one-on-one inservice training and appropriate disciplinary action if warranted for nursing staff observed. **Systemic Change(s):** The facility Policy and Procedure for medication administration and has been reviewed and no changes are warranted at this time. All Licensed nursing staff will be inserviced by the DON or ADON on the facility policy and procedure for medication administration. Inservices will include administering medication per physician order and the 5 rights of medication administration.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 759	Continued From page 64 label. After the medication pass and pour observation the surveyor reconciled the Residents medications. The clinical record included orders for sertraline 25 mg give one tab po (by mouth) daily. The Resident was previously on 50 mg of sertraline it had been changed on 01/25/19 to 25 mg. On 03/20/19 at 9:21 a.m., the surveyor and LPN #2 checked the medication cart for this medication. LPN #2 pulled 2 medication cards from the medication cart sertraline 25 mg (current dose) and sertraline 50 mg (previous dose). LPN #2 verbalized that she could not be sure but thought she had administered the 25 mg and handed the surveyor the wrong card. The administrator and nurse consultant were notified of the issue regarding the Residents sertraline on 03/20/19 at 9:49 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference, 2. For Resident #46, the facility staff failed to administer the Residents zantac. The clinical record review revealed that Resident #46 had been re-admitted to the facility 09/21/07. Diagnoses included, but were not limited to, non-traumatic subdural hematoma, gastroesophageal reflux disease, hypertension, and diabetes. Section C (cognitive patterns) of the Residents significant change MDS (minimum data set)	F 759	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON, Unit Manager and/or designee will conduct threerandom weekly medication passobservations of licensed nurses to monitor for compliance. Any negatives findings will be addressed at the time of discovery and appropriate disciplinary action will be taken. All discrepancies found in 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: 5/5/19**	

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

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	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 759	Continued From page 65 assessment with an ARD (assessment reference date) of 02/06/19 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. On 03/20/19 at 7:38 a.m., the surveyor observed LPN (licensed practical nurse) #1 prepare and administer Resident #46's morning medications. These medications included atenolol, enalapril, januvia, valsartan, hydrochlorothiazide, carbamazepine, senna, loratadine, and lactulose. When reviewing the Residents physician orders it was noted that the Resident also had orders for multivitamin, artificial tear eye drops, sodium chloride, and zantac. The surveyor did not see these medications administered. On 03/20/19 at 9:25 a.m., the surveyor interviewed LPN #1 regarding the missed medications. LPN #1 stated she had went back and administered everything but the zantac. LPN #1 stated, "I don't remember the zantac." After reviewing the EHR (electronic health record) LPN #1 stated I missed the zantac. The administrator and nurse consultant were notified of the issue regarding the Residents zantac on 03/20/19 at 9:49 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 759		
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	F 761	**F761** **Corrective Action(s):** LPN #2 has received one-on-one inservice training from the DON/designee on the Medication Administration Policy to include storing all medications in a locked medication cart when medication is not in line of sight or in control of the Licensed Nurse. A facility incident & accident report was completed for this incident.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

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HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 761	Continued From page 66 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. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to ensure that medications were properly stored on 1 of 2 units, unit C. The findings included: 1. The facility staff failed to secure the medication omeprazole. LPN (licensed practical nurse) #2 left a bottle of omeprazole out of her view and on the top of the medication cart. On 03/20/19 at 7:53 a.m., during a medication	F 761	The 3cc normal saline syringe found in resident #46's room was disposed of. LPN #2 responsible for overseeing the care of resident 46 has received disciplinary action for leaving medication at the resident's bedside unattended and has received one-on-one inservice training from the DON/designee on proper medication administration and storage of medications in a locked medication cart when not in the line of site or in control of the licensed nurse. A facility Incident & accident form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All unit Medication Carts and resident rooms may have been potentially affected. The DON and/or designee will conduct a 100% review of all licensed nurses during medication passes to identify any medication carts that are left unlocked or unattended during medication passes. A 100% review of all resident rooms will be completed to identify any resident rooms with medications or biologicals left in the resident rooms unattended. Any/all negative findings will be corrected at time of discovery. A facility Incident and Accident form will be completed for each incident identified. **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 and/or regional nurse consultant on the facility policy and procedure for storing medications and biological to include not	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 761	Continued From page 67 pass and pour observation LPN #2 did not have a Residents stock medication esomeprazole for administration. After looking through the medication cart LPN #2 stated she would have to obtain the medication from the medication room. LPN #2 went to the medication room and obtained a bottle of omeprazole. Upon returning to the medication cart LPN #2 stated she did not know if this was the correct medication and stated she was going to check a drug book. LPN #2 left the bottle of omeprazole on top of the medication cart and went down the hall leaving her cart with the medication on top and out of her view. LPN #2 then returned to her cart with another bottle of medication for administration. The surveyor observed 3 different staff members in the hallway during the period that LPN #2 was out of the vicinity of the medication cart. On 03/20/19 at 9:21 a.m., LPN #2 was asked about leaving the medication unattended and out of their view, LPN #2 stated she had gotten nervous. The administrator and nurse consultant were notified of the issue regarding the medication being left on top of the medication cart on 03/20/19 at 9:49 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to store medications in a secured location in Resident #46's room. The clinical record of Resident #46 was reviewed 3/19/19 through 3/21/19. Resident #46 was	F 761	leaving medications on the medication carts or in resident rooms unattended. The Pharmacy consultant will check each medication carts and medication room for improper storage of medications monthly during scheduled visits. **Monitoring:** The DON is responsible for maintaining compliance. The DON or designee will perform 3 random weekly audits of the medication carts medication rooms and resident rooms to monitor for compliance. All discrepancies found in these audits will be corrected at the time of discovery and appropriate disciplinary action taken as warranted. 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: 5/5/19**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 68	F 761		

admitted to the facility 6/27/17 and readmitted 9/21/07 with diagnoses that included non-displaced fracture of lateral malleolus right fibula, non-traumatic subdural hemorrhage, constipation, gastroesophageal reflux disease, hypertension, Vitamin deficiency, convulsions, benign prostatic hyperplasia, diabetes mellitus type 2, chronic hepatitis, dry eye syndrome, and anemia.

Resident #46's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15.

On 3/19/19 at 5:00 p.m., the surveyor entered the room of Resident #46 to interview the resident. Upon entrance to the room, the surveyor observed a syringe labeled Normal Saline 3cc (cubic centimeters) IV (intravenous). The syringe was in a plastic protective sleeve. The surveyor did not observe a needle on the syringe.

The surveyor informed licensed practical nurse #2 of the above observation and gave the syringe to her. L.P.N. #2 stated Resident #46's roommate was transferred to the hospital this morning and the syringe was on hand for that resident.

Resident #46 did not have March 2019 physician orders for Normal Saline 3 cc IV.

The surveyor informed the administrator, the director of nursing and the corporate registered nurse on 3/19/19 at 5:40 p.m. and requested the facility policy on medication storage.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 761	Continued From page 69 The facility policy titled "Storage of Medications" read in part "8. Drugs shall be stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Each resident's medications shall be assigned to an individual cubicle, drawer, or other holding area to prevent the possibility of mixing medications of several residents." No further information was provided prior to the exit conference on 3/21/19.	F 761		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842	**F842** **Corrective Action(s):** Resident #46's medical record has been reviewed and the misfiled Urine culture results for resident #160 have been removed from resident #46's medical record and filed in Resident #160's medical record. A facility incident and accident form has been completed for this incident. Resident #94's Durable Do Not Resuscitate (DNR) has been obtained and has been filed in resident #94's medical record. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. A 100% audit of all resident medical records will be conducted by the DON, ADONand/or Medical Records clerk to identify residents at risk for an inaccurate medical record filing and missing DNR documentation. All negative findings will be clarified and/or corrected at time of discovery and the attending physician notified of the incident. A facility Incident & Accident form will be completed for each negative finding.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 70 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff and Medical Records clerk will be inserviced by the DON or regional nurse consultant on the clinical documentation standards per facility policy and procedure. This training will include the standards for maintaining accurate medical records and clinical documentation to include accurate documentation of medical information in the appropriate medical record and maintaining DNR forms and advance directives in the resident medical record. **Monitoring:** The DON is responsible for maintaining compliance. The DON,ADON and/or designee will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be clarified and corrected at time of discovery and disciplinary action will be taken as needed. The results of this audit will be provided to the Quality Assurance Committee for analysis and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 5/5/19**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 842	Continued From page 71 This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 2 of 26 residents (Resident #46 and Resident #94). The findings included: 1. The facility staff incorrectly filed the results of Resident #160's laboratory test on Resident #46's clinical record. The 1/14/19 urine culture results had physician orders for antibiotics for Resident #160 and had been noted by licensed practical nurse #1 (L.P.N. #1). The clinical record of Resident #46 was reviewed 3/19/19 through 3/21/19. Resident #46 was admitted to the facility 6/27/17 and readmitted 9/21/07 with diagnoses that included non-displaced fracture of lateral malleolus right fibula, non-traumatic subdural hemorrhage, constipation, gastroesophageal reflux disease, hypertension, Vitamin deficiency, convulsions, benign prostatic hyperplasia, diabetes mellitus type 2, chronic hepatitis, dry eye syndrome, and anemia. Resident #46's significant change in minimum data set (MDS) assessment with an assessment reference date (ARD) of 2/6/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. The surveyor reviewed Resident #46's laboratory section on 3/21/19. During the review, the surveyor found the results of a urine culture dated 1/12/19 0838 for Resident #160. The urine	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 842	Continued From page 72	F 842		

culture results also had specific orders for an antibiotic-Cipro 500 mg (milligrams) q (every) 12 x 5 days-dated 1/14/19 written by the family nurse practitioner and noted by licensed practical nurse #1.

Resident #46 did not have an order for a urine culture and sensitivity in January 2019.

The clinical record of Resident #160 was reviewed 3/21/19. Resident #160 was admitted to the facility 12/18/18 and readmitted 1/7/19 with diagnoses that included but not limited to cerebral infarction, hemiplegia following cerebral infarction affecting left non-dominant side, ST elevation, cardiomegaly, hypertension, dysphagia, hyperlipidemia, anxiety, obstructive and reflux uropathy, acute upper respiratory infection, and embolism and thrombosis of arteries of lower extremities.

Resident #160's 30 day minimum data set (MDS) with an assessment reference date (ARD) of 2/5/19 assessed the resident with short term memory problems, long term memory problems, and moderately impaired cognitive skills for decision making-decisions poor; needs cues and supervision.

Resident #160 had orders dated 1/10/19 for a UA (urinalysis) w (with) culture/sensitivity dx (diagnosis) hematuria.

The surveyor informed the director of nursing (DON) of the above concern on 3/21/19 at 10:19 a.m. The surveyor asked the director of nursing who was responsible for filing laboratory results in the medical record. The DON stated (other #1) and the nurses look at the laboratory results. The

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 73 surveyor requested the facility policy on charting. The facility policy titled "Charting and Documentation" read in part "3. Documentation in the medical record will be objective, complete, and accurate." No further information was provided prior to the exit conference on 3/21/19. 2. The facility staff failed to ensure Resident #94's DNR (do not resuscitate) was located in the clinical record. The clinical record of Resident #94 was reviewed 3/19/19 through 3/21/19. Resident #94 was admitted to the facility 12/23/15 and readmitted 1/14/18 with diagnoses that included but not limited to acute on chronic combined systolic and diastolic heart failure, atherosclerotic heart disease, atrial fibrillation, hemiplegia following cerebral infarction affecting left non-dominant side, type 2 diabetes mellitus, and hypertension. Resident #94's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 3/5/19 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #94's March 2019 physician's orders read "Do Not Resuscitate (DNR) start date 1/15/18." The surveyor reviewed the clinical record and was unable to locate the DNR. The surveyor informed the assistant director of nursing of the above concern on 3/21/19 at 11:49 a.m.	F 842		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 842	Continued From page 74 The assistant director of nursing (ADON) informed the surveyor that she was not able to locate the DDNR (durable do not resuscitate) in the clinical record. The ADON stated the hospital was called and the hospital faxed a copy of the DDNR to the facility. The facility policy titled "Charting and Documentation" read in part "3. Documentation in the medical record will be objective, complete, and accurate." No further information was provided prior to the exit conference on 3/21/19.	F 842		
F 880 SS=E	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	F 880	**F880** **Corrective Action(s):** The soiled linen in the floor was removed and the floor was cleaned per facility policy/procedure. C.N.A. #1 who placed dirty linen on the floor of Resident #63's room after morning care has received disciplinary action and one-on-one inservice training by the infection preventionist on the proper storage and disposal of soiled linen. A facility incident & accident form was completed for this incident The attending physician for resident #259 was notified that the facility failed to ensure the correct Isolation precautions were implemented when caring for resident #259 and the facility did not provide a soiled linen receptacle for disposing of dirty PPE prior to leaving the resident room. A facility Incident & Accident form was completed for this incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 75 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, 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.	F 880	Resident #310's order for isolation was clarified with the physician on 3/19/19 and the physician discontinued the isolation. The LPTA who entered the resident's room without donning PPE has received disciplinary action and one-on-one inservice training by the infection preventionist on donning/doffing PPE. CNA #1 who exited resident #159's room without washing her hands has received disciplinary action and one-on-one inservice training from the infection preventionist on donning/doffing PPE and handwashing. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected by improper infection control practices related to isolation and PPE. The Infection Preventionist has clarified isolation orders on all residents with current isolation orders with their respective attending physicians. All staff have been inserviced on the isolation precautions in place for all residents currently having orders for isolation. Additionally, all staff have received inservice training on donning/doffing PPE; required equipment; and handwashing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 76 §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, clinical record review, staff interview and facility document review the facility staff failed to follow established infection control procedures for 5 of 26 Residents,#63, #259, #310, #81 and #159. The findings included: 1. For Resident #63, the facility staff failed to ensure that dirty linen was kept off the floor. The clinical record review revealed that Resident #63 had been admitted to the facility 09/20/17. Diagnoses included, but were not limited to, weakness, heart failure, Alzheimer's disease, dementia, and hypertension. Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 02/18/19 had been coded 1/1/2 to indicate the Resident had problems with long and short term memory and was moderately impaired in cognitive skills for daily decision making. On 03/19/19 at 8:59 a.m., during initial tour of the facility, the surveyor observed a large pile of crumpled up linen in floor of the Residents room. The Resident was up in their wheelchair and the Residents bed was observed to be bare of any linen. During this observation CNA (certified nursing assistant) #1 entered the room and picked up the linen from the floor. When asked if	F 880	The infection preventionist/designee will review isolation orders for residents at each morning standup meeting. When residents reside in the facility and have isolation orders, the infection preventionist will complete 3 weekly observations of staff and/or visitors to ensure proper use. 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 Infection Control policy and medication administration policy and procedure have been reviewed and no changes are warranted at this time. The infection preventionist has inserviced all staff on transmission based precautions; donning/doffing PPE; required equipment; and handwashing. The infection preventionist has also re-inserviced nursing staff on visitor education of donning/doffing of PPE.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 77 linen was supposed to be in floor she stated no it is not and placed the linen in a closed barrel out on the hall. On 03/20/19 at 11:28 a.m., during an interview with the infection control nurse this nurse verbalized to the surveyor that they discussed linen in the floor during CNA meetings. The administrative staff were notified of the issue regarding the Residents linen during a meeting with the survey team on 03/19/19 at 5:40 p.m. and again on 03/20/19 at 3:55 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #259, the facility staff failed to ensure the Resident was in the correct isolation and failed to provide a container for disposal of PPE (personal protective equipment). The clinical record review revealed that the Resident had been admitted to the facility on 03/14/19. Diagnoses included, but were not limited to, weakness, insomnia, benign prostatic hyperplasia, heart failure, and hypertension. There was no completed MDS (minimum data set) assessment on this Resident. However, the Resident was alert and orientated to person and place. During initial tour of the facility on 03/19/19 at approximately 8:45 a.m., the facility staff identified this Resident as being in contact isolation. Upon approaching the Resident room, the surveyor observed a plastic container that	F 880	**Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will review isolation orders with facility leadership during the weekly risk mgmt and will complete 3 weekly observations of staff and/or visitors to ensure proper use. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. The infection preventionist will complete 3 weekly observations of staff and/or visitors to monitor compliance. Any negative findings will be addressed at time of discovery and disciplinary action. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: 5/5/19**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 78	F 880		

contained PPE (gloves, gown, and mask) and a sign outside the Residents door that stated to see the nurse. Prior to entering the room, the surveyor dressed out in the PPE provided by the facility.

Upon removing the PPE and preparing to exit the room, the surveyor was unable to locate any infection control container to place the used PPE. The surveyor looked outside in the hallway and asked the staff in the hall about a container. The staff placed a closed barrel in the Residents room to discard the used PPE.

On 03/19/19 at 9:34 a.m., the ADON (assistant director of nursing) identified the infection, as being in the Residents sputum and stated there should have been a barrel in the room.

During an interview with the infection control nurse on 03/19/19 at 12:08 p.m., the designated infection control nurse stated the Resident was on contact isolation, they had spoken with the doctor, and they were going to discontinue the isolation. The infection control nurse stated the Resident should have had a barrel in their room to place the dirty PPE. The infection control nurse was also asked to confirm the type of isolation the Resident should have been placed in.

On 03/20/19 at 11:28 a.m., the infection control nurse verbalized to the surveyor that the she had messed up and the Resident should have been in droplet isolation. However, he had been in contact at the hospital.

A review of the Residents clinical record revealed that the Resident was placed on contact isolation on 03/14/19. This had been discontinued on

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

(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 79 03/19/19. The Resident was in a private room. The Residents comprehensive care plan included the problem area contact isolation related to enterobacter of sputum. The facility policy titled "Isolation-Categories of Transmission-Based Precautions" included the following, "...Droplet Precautions may be implemented for an individual documented or suspected to be infected with microorganisms transmitted by droplets ...that can be generated by the individual coughing, sneezing, talking ..." The administrative staff were notified of the issue regarding the Residents infection control status on 03/19/19 at 5:40 p.m. and again on 03/20/19 at 3:55 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #310, the facility staff failed to initiate the appropriate infection control guidelines and failed to provide a container for disposal of PPE (personal protective equipment). The clinical record review revealed that the Resident had been admitted to the facility on 03/15/19. Diagnoses included, but were not limited to, weakness, Parkinson's disease, diabetes, dementia, and hypertension. There was no completed MDS (minimum data set) assessment on this Resident. The Resident was orientated to self. On 03/19/19 at 8:50 a.m., the surveyor observed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 880	Continued From page 80	F 880		

an isolation sign on the outside of the Resident's door this sign directed any person that would be entering the room to see the nursing staff. The surveyor dressed out in the PPE provided in the cart outside the Residents room. Upon removing the PPE, the surveyor was unable to locate any infection control container to place the used PPE. The surveyor looked out into the hallway and CNA (certified nursing assistant) #1 approached the Resident's room stated the Resident was not on isolation and that the signage was from the previous Resident that was in this room. CNA #1 then removed the isolation sign, repositioned the cart from between the two rooms, and placed it further up the hall. After the signage and PPE equipment had been removed, a second surveyor entered this room with no PPE in place.

During an interview with the infection control nurse, this nurse identified this Resident as being on contact isolation due to enterobacter in their urine.

The clinical record included a physicians order dated 03/15/19 that read "PROVIDE CONTACT ISOLATION RELATED TO ENTEROBACTER IN URINE."

The Residents comprehensive care plan included the problems area UTI (urinary tract infection). Approaches included, but were not limited to, "PROVIDE CONTACT ISOLATION RELATED TO ENTEROBACTER IN URINE, PLACE SIGN ON DOOR, PROVIDE GOWN, GLOVES, MASK..."

On 03/19/19 at 12:25 p.m., during an interview with CNA #1 this CNA verbalized to the surveyor that they had thought the previous Resident that was in this room was on isolation. CNA #1

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 880	Continued From page 81 acknowledged she had removed the sign and stated they had been off the weekend and that is when the Resident had been admitted. CNA #1 stated no one told me yesterday she was on isolation. I was in the room yesterday. The administrative staff were notified of the issues regarding the Residents infection control status during a meeting with the survey team on 03/19/19 at 5:40 p.m. The Residents isolation was discontinued on 03/19/19. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #81 the facility staff failed to maintain an effective infection control program. Resident #81 was admitted to the facility on 01/29/19. Diagnoses included but not limited to cancer, coronary artery disease, hypertension, gastroesophageal reflux disease, benign prostatic hyperplasia, hyperlipidemia, hypothyroidism, depression, chronic obstructive pulmonary disease, and pseudomonas bronchitis. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 02/05/19 coded the Resident as 5 out of 15 in section C, cognitive patterns. This is an admission MDS. Resident #81's CCP (comprehensive care plan) was reviewed and contained a care plan for "At risk for complaints of SOB (shortness of breath) and acute upper resp. (respiratory) infections related to DX: (diagnosis) bronchitis". Approaches for this care plan included "Requires	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 82 droplet isolation r/t (related to) pseudomonas of sputum". On 03/2019 at approximately 1230, surveyor observed LPTA (licensed physical therapy assistant) assisting with lunch trays. LPTA took the lunch tray for the Resident's roommate, and entered the room without donning any PPE (personal protective equipment). Surveyor spoke with the infection control nurse on 03/20/19 at approximately 1325. Surveyor asked infection control nurse if the LPTA should have entered the room without donning PPE, and the infection control nurse stated that he should not have. The surveyor requested and was provided with a facility policy entitled "Isolation-Categories of Transmission-Based Precautions", which read in part "Droplet Precautions 3. Masks will be worn when entering the room". The concern of not following infection control was discussed with the administrative team during a meeting on 03/20/19 at approximately 1555. No further information was provided prior to exit. 5. The facility staff failed to educate visitors on the use of PPE (personal protective equipment) and the staff failed to perform hand hygiene after removing gloves after assisting with wound care for Resident #159. Resident #159 was on contact isolation. The clinical record of Resident #159 was reviewed 3/19/19 through 3/21/19. Resident #159 was admitted 3/14/19 with diagnoses that included but not limited to severe bilateral chronic lymphedema, morbid obesity, obstructive sleep	F 880		

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	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 83 apnea, obstructive and reflux uropathy, hypertension, type 2 diabetes mellitus, hypothyroidism, hyperlipidemia, gastroesophageal reflux disease, and methicillin resistant staphylococcus aureus and MDRO (multi-drug resistant organism) to bilateral lower extremities. Resident #159 was on contact precautions. Resident #159's admission minimum data set (MDS) assessment had not yet been completed. The surveyor observed Resident #159 on 3/19/19 at 2:11 p.m. Resident #159 had a sign on the door directing staff/visitors to see nurse before entering the room. Also at the entrance to the room was a 3-drawer cart containing gloves, gowns, and masks. The surveyor observed a visitor sitting in the chair at the end of Resident #159's bed. The surveyor did not observe any PPE on the visitor. The surveyor observed Resident #159 again on 3/19/19 at 4:53 p.m. The 3-drawer cart did not have any gloves. The visitor was observed again without PPE in use-no gloves or gowns. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 3/19/19 at 5:55 p.m. and requested the infection control policy on contact precautions. The surveyor interviewed Resident #159's visitor on 3/20/19. The visitor was asked if any staff had explained the signage on the door. The visitor stated no. The surveyor observed wound care on 3/20/19 at	F 880		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL GRUNDY	2966 SLATE CREEK ROAD GRUNDY, VA 24614

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F 880	Continued From page 84 12:49 p.m. with licensed practical nurse #4. Certified nursing assistant #1 had gloved and gowned prior to entering the room. Upon completion of the wound care, L.P.N. #4 placed soiled bandages in the barrel, removed gloves and gowns and hands were washed. CNA #1 removed gloves and gown and left the room. No hand-washing observed or hand hygiene done. The surveyor spoke with L.P.N. #4 about the C.N.A. observation. L.P.N. #4 stated, "She didn't wash her hands." The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern on 3/20/19 at 3:54 p.m. and interviewed the infection control registered nurse on 3/21/19 at 1:07 p.m. The infection control nurse stated she was informed of C.N.A. #1 not washing her hands after removing gloves. She stated she expected staff to wash hands or use purell. The surveyor reviewed the facility policy titled, "Isolation-Categories of Transmission-Based Precautions" on 3/21/19. The policy read in part "5. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and type of precaution. Contact Precautions 4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room. 5. Staff and visitors will wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potentially contaminated environmental surfaces with clothing after gown is removed."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495259	A. BUILDING _____ B. WING _____	03/21/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 85 The surveyor reviewed the facility policy titled "Handwashing/Hand Hygiene" on 3/21/19. The policy read in part: "7. Use an alcohol-based hand rub containing at least 62% alcohol; or alternately, soap and water for the following situations: f. before donning sterile gloves m. after removing gloves. n. Before and after entering isolation precaution settings. 8. Hand hygiene is the final step after removing and disposing of personal protective equipment. 9. The use of gloves does not replace handwashing/hand hygiene. Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare-associated infections." No further information was provided prior to the exit conference on 3/21/19.	F 880		
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, Resident interview, and staff interview, the facility staff failed to maintain a safe and hazard free environment. The findings included: The deck outside the back of the facility was observed with rotted and warped boards.	F 921	**F921** **Corrective Action(s):** The deck at the back of the facility identified as having rotten and warped deck boards has been completely taken down and removed from the facility. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residential, and common areas have the potential to be affected. The Maintenance Director will perform a documented walkthrough inspection of the facility to identify any areas of concern related to patient and staff safety or equipment repair needs. Any/All negative findings will be documented and reviewed with the administrator to prioritize corrections that will need to be made.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 921	Continued From page 86 On 3/19/19 at 3:00 p.m., during an interview with Resident #108, outside the dining area, this Resident expressed a concern over not being able to use the outside deck, as the deck was rotten. The surveyor immediately checked the deck area. The facility had placed a park bench across the entryway to this deck. However, the surveyor was able to push the park bench out of the way and gain access to the deck. The surveyor checked the deck and identified two boards that were rotten, boards that were warped, and boards that were uneven. The surveyor asked the facility administrator, maintenance director, and nurse consultant to accompany them to the outside deck. During this observation two decking boards were identified that were rotten, spongy, and moveable. Other boards were identified that were warped and uneven. The facility administrator and maintenance director stated they would place a barrier across the entryway. The nurse consultant stated she would stay in the area until it was addressed. Two ambulatory Residents were observed in the vicinity and another Resident came out into the area during this observation period. The facility dietician was able to visualize the Residents outside from where she was sitting in the dining area. There was no staff present outside during the initial observation. On 3/19/19 at 3:51 p.m., the maintenance director verbalized to the survey team that the	F 921	**Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director will provide inservices to all staff on the policy and procedure for proper notification to use when repairs are needed throughout the facility. This will include reporting broken/unusable furniture, wheelchairs and other resident care equipment. These maintenance request logs will be reviewed by the administrator weekly for completion of repairs. **Monitoring:** The Maintenance Director is responsible for maintaining compliance. The QA Program includes facility audit tools for monitoring compliance. The Maintenance Director will complete the audit weekly to monitor for compliance. 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: 5/5/19**	

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

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	495259	A. BUILDING _____ B. WING _____	03/21/2019

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F 921	Continued From page 87 deck was 7 inches off the ground at the lowest point and 2 foot at the highest. When asked who had placed the park bench across the entranceway to the deck the facility identified this person as being the activity director. The facility administrator and maintenance director stated that they had blocked off the entryway by nailing boards across the entrance. The surveyor checked the area and observed the boards to be secure and in place. The administrator stated they would either replace all the boards or may just demolish the deck. The administrator and maintenance director stated the deck was inspected in October/November and a couple of boards had been replaced. The surveyor interviewed the activity assistant on 03/21/19 at 9:52 a.m., during this interview the activity assistant verbalized to the surveyor that the activity director was out of town and that the boy scouts had redone the deck but that the winter had been rough on the deck. The activity assistant also stated there was caution tape across the deck and she was not sure what had happened to it and she was unsure as to who had placed the park bench across the entrance. The activity assistant then added I had never seen a Resident out there before without staff. They never go outside without supervision. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 921		