STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495317	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL DILLWYN	119 BRICKYARD DRIVE DILLWYN, VA 23936

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 06/25/2019 through 06/27/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 06/25/2019 through 06/27/2019. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One complaint was investigated during the survey. The census in this 60 certified bed facility was 59 at the time of the survey. The survey sample consisted of 36 current resident reviews and 4 closed record reviews.	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F550** **Corrective Action(s):** An Incident & Accident form was completed for Residents #28, #13, #29, #57 who were not fed in a dignified manner during the breakfast meal. An Incident & Accident form was completed for resident #35 who was sitting at her table waiting on her meal tray while her table mates had their meals and were eating. RECEIVED JUL 23 2019 VDH/OLC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Amanda H. Moore, LNHA | Administrator | July 19, 2019

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide a dining experience in a manner and in an environment that promotes respect and dignity for five of 40 residents in the survey sample, Residents #28, #13, #29, #57 and #35. The findings include: 1. The facility staff failed to provide Resident #28 a dignified dining experience by hand feeding the	F 550	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have the potentially been affected. The Administrator and DON will assess the dining experience and the process for meal delivery in facility and dining room to establish a formal dining process that promotes respect and dignity for all residents during meal times, to prevent meals from being served in the hallway and to ensure all staff are providing a dignified dining experience and providing assistance to the residents in a timely manner. **Systemic Change(s):** Facility policy and procedures were reviewed. No changes are warranted at this time. The DON and/or Social Services will inservice all staff on the facility policy and procedure regarding resident rights and dignity during mealtimes. The inservice will also cover the procedure for proper meal tray delivery, set up and providing a dignified and respectful dining experience and to ensure all residents are served in a dignified location and a dignified manner and receive meal assistance as needed.	

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F 550	Continued From page 2 resident their breakfast in the middle of the hallway. Resident #28 was admitted to the facility on 6/23/17 with diagnoses that include but were not limited to: Parkinson's Disease [a slowly progressive neurological disorder characterized by resting tremor, shuffling gait, stooped posture, rolling motions of the fingers, drooling and muscle weakness, sometimes with emotional instability. (1)], and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/11/19, coded the resident as scoring a "12" on the BIMS (brief interview for mental status) score, indicating she was moderately impaired to make daily cognitive decisions. The resident was coded in Section G - Functional Status as being totally dependent upon the staff for all of her activities of daily living, including eating. The comprehensive care plan dated, 4/9/19, documented in part, "Problem: (Resident #28) required mechanically altered diet for her well being, weight management and enjoyment." The "Approaches" documented in part, "Provide a pleasant dining environment with enough time to consume the meal. Assist with meal set up as needed from tray set up to total feeding by staff." Observation was made of Resident #28 in the hallway sitting in her wheelchair, with her bedside table in front of her. A CNA (certified nursing assistant) was observed feeding her, her breakfast on 6/26/19 at 8:12 a.m. An interview was conducted with LPN (licensed	F 550	**Monitoring:** The DON and Administrator are responsible for compliance. The DON or Administrator and/or designee will complete the 3 meal pass audit weekly to monitor for compliance. All negative findings will be corrected at the time of discovery. The audit findings will be reported to the Risk Management Committee for review. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: 08/10/2019**	

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F 550	Continued From page 3	F 550		

practical nurse) #2, on 6/27/19 at 10:43 a.m. When asked if she sees residents being fed in the hallways, LPN #2 stated, "Yes. To me, it's a privacy concern. There really need to take the residents into the room and stay with them. "When asked how she would feel if she were fed in the middle of the hallway, LPN #2 stated, "I wouldn't want it." When asked how that would make her feel, LPN #2 stated, "I would feel demeaned." When asked if this is a dignity issue, LPN #2 stated, "Yes, Ma'am. I wouldn't want my mother to eat her meals in the hallway and she's a resident here at the facility. When we give medications and treatments, we take the resident into their room. No one else needs to know what is going on with them." When asked if she had ever expressed this to anyone, LPN #2 stated, "No."

An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/27/19 at 11:04 a.m., regarding the observation of residents being fed in the hallway. ASM #2 stated, "We can't take her (another resident not observed) into the dining room, the other resident complain of her. In the mornings, we bring them out in the hallways so we don't keep them confined in their rooms. The staff can still monitor what is going on, on the floor. We can keep an eye on the fall risk people and those trying to leave the building. We have residents that wander. "When asked how she would feel if someone is hand feeding you, ASM #2 stated, "If I'm demented, I wouldn't know what is going on. It's not that they are degrading them. They eat a whole lot better if the staff is with them." When asked why the dining room is not open for breakfast, ASM #2 stated, "It's never been open. It's open for anyone what wants to go up there.

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F 550	Continued From page 4 The staff converse with the residents and the residents enjoy it and eat better." When asked if being fed in the hallway was being respectful and providing a dignified existence, ASM #2 stated, "No, someone coming in from the outside would see it that way. It's to bring the residents out and watching for the other resident's safety." When asked if it is the staff's responsibility to provide a dignity and privacy, ASM #2 stated, "Yes." The facility's policy "RESIDENT RIGHTS" documented, "10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for your personal needs." Administrative staff member (ASM) #1, the administrator, and ASM #2, were made aware of the above concern on 6/27/19 at 4:04 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 437. 2. The facility staff failed to provide Resident #13 a dignified dining experience by hand feeding the resident their breakfast in the middle of the hallway. Resident #13 was admitted to the facility on 10/04/06 with diagnoses that included but were not limited to: stroke, high blood pressure, dementia and GERD - gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the	F 550		

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F 550	Continued From page 5 esophagus, commonly known as heartburn (1)]. The most recent MDS (minimum data set) Assessment, an annual assessment, with an assessment reference date of 4/23/19, coded the resident as having both short and long-term memory difficulties and was coded as being moderately impaired to make cognitive daily decisions. The resident was coded in Section G - Functional Status as requiring limited to extensive assistance for all of her activities of daily living, including eating. Observation was made of Resident #13 in the hallway sitting in her wheelchair, with her bedside table in front of her. A CNA (certified nursing assistant), was observed sitting next to Resident #13 and was feeding her, her breakfast, on 6/26/19 at 8:12 a.m. The comprehensive care plan dated, 4/24/19, documented in part, "Problem: (Resident #13) has potential for decline in nutrition related to her chronic anemia and GERD, hx (history) of CVA (stroke) with generalized weakness and cognitive issues. She has a poor appetite, dysphagia (difficulty swallowing) at risk for aspiration and wt (weight) loss." The "Approaches" documented in part, "Assist her to feed as needed. Offer meals in a clean and inviting atmosphere." An interview was conducted with LPN (licensed practical nurse) #2, on 6/27/19 at 10:43 a.m. When asked if she sees residents being fed in the hallways, LPN #2 stated, "Yes. To me, it's a privacy concern. There really need to take the residents into the room and stay with them. "When asked how she would feel if she were fed in the middle of the hallway, LPN #2 stated, "I	F 550		

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F 550	Continued From page 6 wouldn't want it." When asked how that would make her feel, LPN #2 stated, "I would feel demeaned." When asked if this is a dignity issue, LPN #2 stated, "Yes, Ma'am. I wouldn't want my mother to eat her meals in the hallway and she's a resident here at the facility. When we give medications and treatments, we take the resident into their room. No one else needs to know what is going on with them." When asked if she had ever expressed this to anyone, LPN #2 stated, "No." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/27/19 at 11:04 a.m., regarding the observation of residents being fed in the hallway. ASM #2 stated, "We can't take her (another resident not observed) into the dining room, the other resident complain of her. In the mornings, we bring them out in the hallways so we don't keep them confined in their rooms. The staff can still monitor what is going on, on the floor. We can keep an eye on the fall risk people and those trying to leave the building. We have residents that wander. "When asked how she would feel if someone is hand feeding you, ASM #2 stated, "If I'm demented, I wouldn't know what is going on. It's not that they are degrading them. They eat a whole lot better if the staff is with them." When asked why the dining room is not open for breakfast, ASM #2 stated, "It's never been open. It's open for anyone what wants to go up there. The staff converse with the residents and the residents enjoy it and eat better." When asked if being fed in the hallway was being respectful and providing a dignified existence, ASM #2 stated, "No, someone coming in from the outside would see it that way. It's to bring the residents out and	F 550		

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F 550	Continued From page 7 watching for the other resident's safety." When asked if it is the staff's responsibility to provide a dignity and privacy, ASM #2 stated, "Yes." The facility's policy "RESIDENT RIGHTS" documented, "10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for your personal needs." Administrative staff member (ASM) #1, the administrator, and ASM #2, were made aware of the above concern on 6/27/19 at 4:04 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. 3. The facility staff failed to provide Resident #29 a dignified dining experience by hand feeding the resident their breakfast in the middle of the hallway. Resident #29 was admitted to the facility on 12/26/13 with diagnoses that included but were not limited to: Alzheimer's disease [a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability. (1)], diabetes, high blood pressure, and rheumatoid arthritis A chronic, destructive disease characterized by joint inflammation. Symptoms are varied, often including fatigue, low grade fever, loss of appetite, morning stiffness, tender, painful swelling of two or more joints, most commonly in fingers, ankles, feet, hips and shoulders. (2).	F 550		

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F 550	Continued From page 8 The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/10/19 coded the resident as having both short and long-term memory difficulties and being moderately impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as requiring limited to extensive assistance for all of her activities of daily living, including extensive assistance for eating. Observation was made of Resident #29 in the hallway sitting in her wheelchair, with her bedside table in front of her. A CNA (certified nursing assistant), was observed sitting next to her and feeding Resident #29, her breakfast, on 6/26/19 at 8:12 a.m. The comprehensive care plan dated,4/5/19, documented in part, "Problem: (Resident #29) is a diabetic and has cardiac DX (diagnoses) ; requires a therapeutic diet mechanically altered diet to manager conditions and maintain her weight." The "Approaches" documented in part, "Ensure a pleasant dining environment and adequate time to consume the meal." An interview was conducted with LPN (licensed practical nurse) #2, on 6/27/19 at 10:43 a.m. When asked if she sees residents being fed in the hallways, LPN #2 stated, "Yes. To me, it's a privacy concern. There really need to take the residents into the room and stay with them. "When asked how she would feel if she were fed in the middle of the hallway, LPN #2 stated, "I wouldn't want it." When asked how that would make her feel, LPN #2 stated, "I would feel demeaned." When asked if this is a dignity issue,	F 550		

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F 550	Continued From page 9 LPN #2 stated, "Yes, Ma'am. I wouldn't want my mother to eat her meals in the hallway and she's a resident here at the facility. When we give medications and treatments, we take the resident into their room. No one else needs to know what is going on with them." When asked if she had ever expressed this to anyone, LPN #2 stated, "No." An interview was conducted with administrative staff member (ASM) #2, the director of nursing, on 6/27/19 at 11:04 a.m., regarding the observation of residents being fed in the hallway. ASM #2 stated, "We can't take her (another resident not observed) into the dining room, the other resident complain of her. In the mornings, we bring them out in the hallways so we don't keep them confined in their rooms. The staff can still monitor what is going on, on the floor. We can keep an eye on the fall risk people and those trying to leave the building. We have residents that wander. "When asked how she would feel if someone is hand feeding you, ASM #2 stated, "If I'm demented, I wouldn't know what is going on. It's not that they are degrading them. They eat a whole lot better if the staff is with them." When asked why the dining room is not open for breakfast, ASM #2 stated, "It's never been open. It's open for anyone what wants to go up there. The staff converse with the residents and the residents enjoy it and eat better." When asked if being fed in the hallway was being respectful and providing a dignified existence, ASM #2 stated, "No, someone coming in from the outside would see it that way. It's to bring the residents out and watching for the other resident's safety." When asked if it is the staff's responsibility to provide a dignity and privacy, ASM #2 stated, "Yes."	F 550		

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F 550	Continued From page 10 The facility's policy "RESIDENT RIGHTS" documented, "10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for your personal needs." Administrative staff member (ASM) #1, the administrator, and ASM #2, were made aware of the above concern on 6/27/19 at 4:04 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 511. 4. The facility staff failed to serve and assist Resident # 57 with her breakfast in a manner to promote dignity. Resident #57 was observed being fed her breakfast in the hallway outside her room while sitting in a Merry Walker (3). Resident # 57 was admitted to the facility on 05/22/2019 with diagnoses that included but were not limited to: dementia (1) and hyperlipidemia (2). Resident # 57's most recent MDS (minimum data set), a 30-Day assessment with an ARD (assessment reference date) of 06/19/19, coded Resident # 57 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition intact for making daily decisions. Resident # 57 was coded as being totally dependent of one staff member for all activities of daily living and being totally dependent of one staff member for eating.	F 550		

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F 550	Continued From page 11 On 06/26/19 at approximately 8:11 a.m., an observation of Resident # 57 revealed she was in the hallway, outside of her room, sitting in a "Merry Walker (3)" with a CNA (certified nursing assistant) standing next her providing feeding assistance. Further observation revealed ASM (administrative staff member) # 1, administrator, was present talking to Resident # 57. On 06/27/19 at approximately 8:10 a.m., an observation of Resident # 57 revealed she was in the hallway, outside of her room, sitting in a wheelchair eating breakfast. The comprehensive care plan for Resident # 57 dated 06/03/2019 documented, "Problem/Need. Resident requires a mechanically altered diet for her weight maintenance. She is at risk for dehydration due to poor mobility, confusion, and poor intake." Under "Approaches" it documented, "Provide a pleasant dining environment with adequate time to consume the meal. Assist with meal tray set up as needed. Resident is fed by staff." On 06/27/19 at 11:04 a.m., an interview was conducted with ASM # 2, director of nursing regarding Resident # 57 eating her meals in the hallway. When asked why residents were being fed in the hallway ASM # 2 stated, "We don't like to keep them confined in their rooms and we bring them out in the hallway and staff can still monitor what is happening on the floor." When asked how she thought it would it make her feel to be fed in the hallway ASM #2 stated, "I never really thought about it, it's not like they (staff) are trying to degrade them, the staff converse with them and the resident's eat better and they enjoy	F 550		

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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
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it." When asked if eating in the hallway provided a dining experience ASM # 2 stated no. When asked if was dignified to be eating in the hallway ASM # 2 stated, "Not from someone coming in from the outside."

The facility's policy "RESIDENT RIGHTS" documented, "10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for your personal needs."

On 06/26/19 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

(2) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.

(3) A walker/chair combination, allowing a person who would normally be placed in a wheelchair to be placed into a Merry Walker, allowing independent and safe walking. End users will be

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F 550	Continued From page 13 able to ambulate independently and safely. This information was obtained from the website: http://www.merrywalker.com/mw-product-detail-home-care-walker.html. 5. The facility staff failed to serve food in a manner to promote Resident # 35's dignity in the facility's main dining room. Resident # 35 was observed sitting in her wheelchair, at a table watching the other four residents seated at the table, eat their lunch while waiting for her meal. Resident # 35 was admitted to the facility on 11/02/2015 with diagnoses that included but were not limited to: bipolar disorder (1), arthritis, dementia with behavioral disturbance (2), contracture of muscle (3), and hyperlipidemia (4). Resident # 35's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/22/19, coded Resident # 35 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 57 was coded as being totally dependent of one staff member for all activities of daily living and being totally dependent of one staff member for eating. On 06/25/19 at 12:23 p.m., an observation was conducted of lunch in the facility's dining room. Observation of a long table revealed five residents at the table, one resident eating independently, three residents being assisted with their meals. Resident # 35 was observed sitting in her wheelchair, at the table watching the other four residents eat their lunch while waiting for her meal. At 12:30 p.m., seven minutes later, CNA (certified nursing assistant) # 3 brought a lunch	F 550		

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tray to Resident # 35. CNA #3 was observed setting up the lunch items and then feeding Resident #35.

On 06/25/19 at 2:11 p.m., an interview was conducted with CNA # 3. When asked if she was in the dining room earlier assisting Resident # 35 with lunch, CNA # 3 stated, "I was at the feeding table assisting (Resident # 35)." When asked what type of assistance Resident # 35 required, CNA # 3 stated, "She is total in everything." When asked if Resident # 35 required a hundred percent assistance with eating, CNA # 3 stated "Yes." CNA #3 was informed of the above observation of Resident # 35 waiting at the table for seven minutes for her food and assistance with eating while four other residents at the same table were eating. CNA # 3 stated, "I was picking up trays when I noticed she wasn't eating and I stopped to get her tray and assist her." When asked to describe the procedure for serving residents at the same table, CNA # 3 stated, "We serve the independent residents first and then the residents who need assistance. We are suppose sever one table at a time." When asked if she thought it was acceptable to have a resident wait for their meal while everyone else at the same table is eating, CNA # 3 stated, "No I don't."

On 06/26/19 at 5:02 p.m., an interview was conducted with OSM (other staff member) # 2, dietary manager. OSM # 2 was asked to describe the procedure for serving residents at the same table. OSM # 2 stated, "Everyone at the same table should be served at once." OSM # 2 was asked how she thought Resident # 35 would feel while she had to wait for a meal while everyone around her was eating. OSM # 2

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stated, "Would feel antsy because everyone around them is eating. Our practice is to serve everyone at the table at once." When asked if it was dignified to the resident to have to wait for their meal while those at the table with them were eating, OSM # 2 stated, "I would consider it to be a dignity concern."

The facility's policy "RESIDENT RIGHTS" documented, "10. Is treated with consideration, respect, and full recognition of his dignity and individuality, including privacy in treatment and in care for your personal needs."

On 06/26/19 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.

(2) Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. They include symptoms such as depression, anxiety psychosis, agitation, aggression, disinhibition, and sleep disturbances. Approximately 30% to 90% of patients with dementia suffer from such behavioral disorders. There are complex interactions between cognitive deficits, psychological symptoms, and behavioral

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F 550	Continued From page 16 abnormalities. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/. (3) A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement. Contractures mostly occur in the skin, the tissues underneath, and the muscles, tendons, ligaments surrounding a joint. They affect range of motion and function in a certain body part. Often, there is also pain. This information was obtained from the website: https://medlineplus.gov/ency/article/003185.htm. (4) Cholesterol is a fat (also called a lipid) that your body needs to work properly. Too much bad cholesterol can increase your chance of getting heart disease, stroke, and other problems. The medical term for high blood cholesterol is lipid disorder, hyperlipidemia, or hypercholesterolemia. This information was obtained from the website: https://medlineplus.gov/ency/article/000403.htm.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to assess one of 40 residents in the survey sample,	F 554	**F554** **Correction Action(s):** The bottle of Tums noted on resident #3's windowsill was removed and placed in the Medication cart and the MD was notified of the finding. Resident #3 has been assessed using the Folstein Mini Mental Exam by the DON to determine if he is able to self-administer his medication. It was determined that the resident is not able to self-administer his medications. A Facility Incident & Accident form was completed for this incident.	

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F 554	Continued From page 17 Resident # 3, for self-administration of medication. The facility staff failed to remove and secure a bottle of 'Tums' (over the counter antacid) from Resident # 3's room. The findings include: Resident # 3 was admitted to the facility on 07/02/2010 with diagnoses that included but were not limited to: history of prostate cancer, retention of urine, and benign prostatic hyperplasia (1). Resident # 3's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/02/19, coded Resident # 3 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 3 was coded as being totally dependent of one staff member for all activities of daily living. On 06/25/19 at 2:30 p.m., an observation of Resident # 3's room revealed a bottle of Tums on Resident # 3's windowsill. On 06/25/19 at 3:15 p.m., an observation of Resident # 3's room revealed a bottle of 'Tums' on Resident # 3's windowsill. When asked about the bottle of Tums on the windowsill, Resident # 3 stated, "I get heartburn once in a while and takes them." When asked where the Tums came from, Resident # 3 stated, "My sister brought them in about a month ago." On 06/25/19 at 4:10 p.m., at the start of the medication administration observation with LON (licensed practical nurse) # 3, she was observed placing a bottle of Tums in a drawer of her	F 554	**Identification of Deficient Practice(s) and Corrective Action(s):** A 100% review of all resident rooms and bedside tables will be completed to check for medications that are being self-administered without assessment or a physician order by the DON, Unit Managers and/or designee. Any resident found to be self-administering medications without a physician order and an appropriate Folstein Mini-Mental Exam to determine their ability to safely and effectively self-administer medications will be corrected at time of discovery. The attending physician will be notified, and a Folstein Mini-Mental Exam will be completed to determine if it is clinically appropriate for the resident to self-administer medications. A facility Incident & Accident form will be completed for all negative findings. **Systemic Change(s):** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. All licensed staff and the interdisciplinary team will be inserviced by the DON and/or regional nurse consultant on the policy and procedure for self administration of medications, assessment used for determining self-administration of medications, as well as documenting in the residents comprehensive care plan and the need to obtain a physicians order for self administration of medication.	

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F 554	Continued From page 18 medication cart. LPN # 3 stated that she had found the bottle of Tums in Resident # 3's room. On 06/25/19 at 4:45 p.m., an interview was conducted with LPN # 3. When asked why she removed the bottle of Tums from Resident # 3's room, LPN # 3 stated, "I don't think he has an order for them, his sister brought them in and he is already prescribed Omeprazole (2)." LPN # 3 stated, "No one should have any medications in their room, over-the-counter or otherwise." When asked if Resident # 3 had taken any of the Tums, LPN # 3 stated, "I asked him and he told me no." On 06/26/19 at 4:52 p.m., an interview was conducted with ASM (administrative staff member0 # 2, director of nursing regarding the bottle of Tums in Resident # 3's room. ASM # 2 stated, "It's not allowed. If there isn't an order for it we don't allow them to keep it, we don't know how much they take or how often. We're unable to monitor it. If a family member comes in in with medication, we take it, get a physician's order for them and store it on the med (medication) cart. If they are alert and the physician approves it we would conduct an assessment and monitor them taking it (medication). It would have to be stored in a secured location. We don't encourage it. We tell the family and resident at the time of admission that if they have any medication(s) they are taking that is not on the medication list that we would keep it on the med cart." On 06/26/19 at approximately 5:55 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit.	F 554	**Monitoring:** The DON is responsible for compliance. The DON, Unit Managers, and/or charge nurse will review all documentation and communication daily for residents self administering medications to ensure medication was taken appropriately. All discrepancies found in these audits will be corrected at time of discovery and reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 08/10/2019**	

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F 554	Continued From page 19 References: (1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html. (2) Prescription omeprazole is used alone or with other medications to treat the symptoms of gastroesophageal reflux disease (GERD), a condition in which backward flow of acid from the stomach causes heartburn and possible injury of the esophagus (the tube between the throat and stomach) in adults and children 1 year of age and older. Prescription omeprazole is used to treat damage from GERD in adults and children 1 month of age and older. Prescription omeprazole is used to allow the esophagus to heal and prevent further damage to the esophagus in adults and children 1 year of age and older with GERD. Prescription omeprazole is also used to treat conditions in which the stomach produces too much acid such as Zollinger-Ellison syndrome in adults. Prescription omeprazole is also used to treat ulcers (sores in the lining of the stomach or intestine) and it is also used with other medications to treat and prevent the return of ulcers caused by a certain type of bacteria (H. pylori) in adults. Nonprescription (over-the-counter) omeprazole is used to treat frequent heartburn (heartburn that occurs at least 2 or more days a week) in adults. Omeprazole is in a class of medications called proton-pump inhibitors. It works by decreasing the amount of acid made in the stomach. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a693050.html.	F 554		

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F 558 SS=D	Continued From page 20 Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was determined that the facility staff failed to provide accommodation of resident needs for one of 40 residents in the survey sample, Resident # 37. The facility staff failed to ensure Resident # 37's call bell (a device with a button that can be pushed to alert staff when assistance is needed), was within the resident's reach. The findings include: Resident # 37 was admitted to the facility on 01/10/19 with a re-admission of 01/28/19 with diagnoses that included but were not limited to benign prostatic hyperplasia (1), heart disease (2), and hypertension (3). Resident # 37's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/27/19, coded Resident # 37 as scoring a zero on the brief interview for mental status (BIMS) of a score of 0 - 15, zero - being severely impaired of cognition for making daily decisions. Resident # 37 was coded as requiring limited assistance of one staff member for activities of daily living. Section G0400 "Functional Limitation in Range of Motion"	F 558	**F558** **Corrective Action(s):** Resident #37's call bell was corrected and is now properly placed. CAN #4 was inserviced on checking for the proper placement of resident call bell for resident #37. A facility Incident & Accident 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/or unit managers will screen 100% of residents for proper call bell placement and use to identify residents at risk. This is to include adaptive call bells. Any/all negative findings identified will be corrected at the time of discovery. An Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes warranted at this time. All staff will be inserviced by the DON on the proper placement and use of resident call bells to ensure they are properly placed within reach of all residents when in their rooms.	

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F 558	Continued From page 21 coded Resident # 37 with, "Impairment on one side" of his upper extremities (shoulder, elbow, wrist, hand). On 06/26/19 at 9:01 a.m., an observation of Resident # 37's room revealed the call bell laying in the middle of the bed. Resident # 37 was observed sitting in his wheelchair at the foot of hi bed. Further observation revealed the call bell was not within reach of Resident # 37. On 06/26/19 at 9:25 a.m., an observation of Resident # 37's room revealed the call bell laying in the middle of the bed. Resident # 37 was observed sitting in his wheelchair at the foot of hi bed. Further observation revealed the call bell was not within reach of Resident # 37. On 06/27/19 at 8:15 a.m., an observation of Resident # 37's room revealed the call bell laying in the middle of the bed. Resident # 37 was observed sitting in his wheelchair at the foot of his bed eating his breakfast on the over-the-bed table in front of him. Further observation revealed the call bell was not within reach of Resident # 37. On 06/27/19 at 2:10 p.m., an observation and interview was conducted with Resident # 37. Resident #37 was sitting in his wheelchair at the foot of his bed. When asked if he used the call bell Resident # 37 stated that he did use it and it was verified with his roommate that Resident # 37 could press the call bell. The comprehensive care plan for Resident # 37 dated 01/24/2019 documented, "Problem/Need. (Resident # 37) requires assist (assistance) with his ADLs due to weakness, poor mobility and cognitive deficits. He is at risk for falls due to	F 558	**Monitoring:** The Unit Managers are responsible for maintaining compliance. DON and/or Unit Managers will complete random daily rounds throughout the day to monitor for correct placement of call bells to monitor for compliance. Any negative findings will be corrective at time of discovery and disciplinary action will be taken as required. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date: 08/10/2019**	

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F 558	Continued From page 22 poor mobility. Resident was admitted with pressure area on his left heel that has opened requires tx (treatment). He is at risk for new pressure areas and MASD (moisture associated skin damage). (Resident # 37) has poor mobility and hx (history) [sic] rt (right) arm cellulitis at risk for unrelieved pain." Under "Approaches", it documented in part, "Call bell within reach." On 06/27/19 at 2:12 p.m., an interview was conducted with CNA (certified nursing assistant) # 4. CNA # 4 was asked to observe the placement of Resident # 37's call bell. When asked if the call bell was within Resident #37's reach, CNA # 4 stated, No it's not within reach. It's supposed to be in reach." CNA # 4 then positioned the call bell to the foot of the bed within Resident # 37's reach. Observation of the call bell revealed that it was long enough to reach from the wall at the head of the bed to just past the foot of Resident # 37's bed and was in reach. The facility's policy "Answering the Call Light" it documented, "General Guidelines. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident." On 06/27/19 at approximately 5:00 p.m., ASM (administrative staff member) # 1, the administrator and ASM # 2, director of nursing were made aware of the findings. No further information was provided prior to exit. References: (1) An enlarged prostate. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/enlargedprostatebph.html.	F 558		

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F 558	Continued From page 23 (2) There are many different forms of heart disease. The most common cause of heart disease is narrowing or blockage of the coronary arteries, the blood vessels that supply blood to the heart itself. This is called coronary artery disease and happens slowly over time. It's the major reason people have heart attacks. Other kinds of heart problems may happen to the valves in the heart, or the heart may not pump well and cause heart failure. Some people are born with heart disease. This information was obtained from the website: https://medlineplus.gov/heartdiseases.html. (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 558		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578	**F578** **Corrective Action(s):** An Incident and Accident form was completed for not offering periodic reviews of the advance directives for residents #46, #3, #4, #42, #10, #17, #35, #9, #31, #16, #11, #39, #42 and #38.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495317	A. BUILDING _____ B. WING _____	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL DILLWYN	119 BRICKYARD DRIVE DILLWYN, VA 23936

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F 578	Continued From page 24 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide periodic reviews of the advance directives for fourteen of 40 residents in the survey sample, Residents #46, #3, #4, #41, #10, #17, #35, #9, #31, #16, #11, #39, #42 and # 38. The findings include: 1. The facility staff failed to evidence information a periodic review was conducted to provide Resident # 46 with the opportunity to develop an	F 578	**Identification of Deficient Practice(s) & Corrective Action(s):** All other residents may have been potentially affected. The Social Services Director will review all resident's medical records to identify residents that have not had a periodic review of their advance directives. Any negative findings will result in the Social Services Director reviewing the advance directives with the resident and/or RP to ensure that the proper code status and advance directives are in place and document in the residents medical record the status of their advance directive and code status. An Incident & Accident form will be completed for each negative finding. **Systemic Change(s);** The Facility policy and procedure was reviewed and no changes are warranted at this time. The Social Services director have been inserviced on the policy and procedure for initiating and reviewing advance directives on admission and every 90 days with the resident and/or RP. The Social Services Director will discuss with each future new Admission their advance directors and resuscitation status upon admission to the facility and every 90 days after admission.	

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F 578	Continued From page 25 advance directive. Resident # 46 was admitted to the facility on 01/23/13 with diagnoses that included but were not limited to hypertension (1), and Alzheimer's disease (2). Resident # 46's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/05/19, coded Resident # 46 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 46 was coded as being independent with activities of daily living. The clinical record and the EHR (electronic health record) for Resident # 46 evidenced Resident # 46 was offered information on developing an advance directive upon admission. Review of the record revealed Resident # 46 had chosen not to execute an advance directive. Further review of the clinical record and the EHR failed to evidence documentation that Resident # 46 was provided periodic review to develop an advance directive. On 06/26/19 at 4:40 p.m., an interview was conducted with OSM (other staff member) # 1, social worked and admissions coordinator. OSM #1 was asked to describe the process staff follows regarding a resident's advance directive. OSM # 1 stated, "Upon admission, I do give information about formulating and advanced directive, and discuss with them their right to form an advance directive, discuss DNR (Do Not Resuscitate) and Full code status at that time. Even if they don't choose to write an advance directive, we have a form on the chart, which is an advance-directive discussion sheet. Quarterly I review the code status, and again ask about	F 578	**Monitoring:** The Social Services Director is responsible for maintaining compliance. The Social Services Director will audit Residents medical records weekly coinciding with the care plan calendar to monitor compliance for reviewing Advance Directives every 90 days with residents and/or RP's. Any/all negative findings will be reported to the Administrator for immediate corrective action to include an investigation. **Completion Date: 08/10/2019**	

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F 578	Continued From page 26	F 578		

advance directive." When asked if she had documentation that she had reviewed the advance directive with Resident #46 or the responsible party, OSM # 1 stated no.

The facility's policy " ADVANCE DIRECTIVES FOR WITHHOLDING OR WITHDRAWING LIFE-PROLONGING PROCEDURES" documented, "Social Services. 2. Follow-up: a. Where the resident chooses not to execute an Advance Medical Directive at the time of admission, Social Services will inquire after 90 days whether there has been any subsequent discussion about, or decision to execute, an Advance Medical Directive. b. If the resident wishes to execute an Advance Medical Directive, or has already done so, the social services staff will arrange for any necessary assistance to the resident, and obtain three (3) copies of the document, for disposition in the same manner, described above, as Advance Medical Directives identified or executed at the time of admission. c. If the resident does not wish to execute an Advance Medical Directive when given the opportunity through the follow-up procedure, it should be documented in the social services notes that the follow-up was done and the resident chose not to make a decision. d. Subsequent follow-up will take place, as the need is indicated and communicated by the nursing staff to the Comprehensive Plan of Care Team, for example, when the residents overall condition is declining, suggesting the increased likelihood that a life-threatening situation may develop, in which the existence of an Advance Medical Directive might serve to spare the resident unnecessary pain and suffering, should that be the wish of the resident. e. Upon determination by the Comprehensive Plan of Care Team, that