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
F 578	Continued From page 27	F 578		

Continued From page 27

circumstances indicate an Advance Medical Directive follow-up is appropriate, the social services staff shall bring the matter to the attention of the residents attending physician, for assistance in obtaining an Advance Medical Directive consistent with the residents medical treatment needs and wishes."

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 above findings.

No further information was provided prior to exit.

References:
(1) A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html.

(2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

2. The facility staff failed to evidence information a periodic review was conducted to provide Resident # 3 with the opportunity to review and make changes to his advance directive.

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

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JUL 23 2019
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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
F 578	Continued From page 28	F 578		

(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.

The clinical record and the EHR (electronic health record) for Resident # 3 evidenced Resident # 3 was offered information on developing an advance directive upon admission. Review of the record revealed Resident # 3 had an advance directive. Further review of the clinical record and the EHR failed to evidence documentation that a periodic review of the residents advanced directive was provided to Resident # 3.

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 if she had documentation that she had periodically reviewed Resident #3's advance directive with the resident or the responsible party. OSM # 1 stated no.

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 above 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.

(2) Prescription omeprazole is used alone or with other medications to treat the symptoms of

F 578 Continued From page 29 F 578

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.

3. The facility staff failed to evidence information a periodic review was conducted to provide Resident # 4 with the opportunity to develop an advance directive.

Resident # 4 was admitted to the facility on 11/24/10 with diagnoses that included but were not limited to dementia (1), hypertension, (2), and

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
F 578	Continued From page 30	F 578		

dysarthria (3). Resident # 4's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/02/19, coded Resident # 4 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.

The clinical record and the EHR (electronic health record) for Resident # 4 evidenced Resident # 4 was offered information on developing an advance directive upon admission. Review of the record revealed Resident # 4 had chosen not to execute an advance directive. Further review of the clinical record and the EHR failed to evidence documentation that Resident # 4 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. When asked if she had documentation that she had periodically reviewed advance directives with Resident #4 or the resident's responsible party, OSM # 1 stated no.

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 above 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:

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
F 578	Continued From page 31 https://medlineplus.gov/ency/article/000739.htm. (2) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (3) A condition in which you have difficulty saying words because of problems with the muscles that help you talk). This information was obtained from the website: https://medlineplus.gov/ency/article/007470.htm. 4. The facility staff failed to evidence information a periodic review was conducted to provide Resident # 41 with the opportunity to develop an advance directive. Resident # 41 was admitted to the facility on 12/07/18 with diagnoses that included but were not limited to high cholesterol, dementia, (1), and diabetes mellitus (2). Resident # 41's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/03/19, coded Resident # 41 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. The clinical record and the EHR (electronic health record) for Resident # 41 evidenced Resident # 41 was offered information on developing an advance directive upon admission. Review of the record revealed Resident # 41 had chosen not to execute an advance directive. Further review of the clinical record and the EHR failed to evidence documentation that Resident # 41 was provided periodic review to develop an advance directive.	F 578		

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
F 578	Continued From page 32	F 578		

On 06/26/19 at 4:40 p.m., an interview was conducted with OSM (other staff member) # 1, social worked and admissions coordinator. When asked if she had documentation that she had periodically reviewed advance directives with Resident #41 or the resident's responsible party, OSM # 1 stated no.

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 above 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) A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

5. The facility staff failed to evidence information a periodic review was conducted to provide Resident # 10 and/or their resident representative with the opportunity to review and make changes to the advance directive.

Resident # 10 was admitted to the facility on 05/17/2010 and a readmission on 05/15/2017

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JUL 23 2019
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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
F 578	Continued From page 33	F 578		

with diagnoses that included but were not limited to cerebral infarction (1), anxiety (2) and dementia (3). Resident # 10's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 04/15/19 coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, two being moderately impaired of cognition for daily decision-making.

The clinical record and the EHR (electronic health record) for Resident # 10 evidenced Resident # 10 was offered information on developing an advance directive upon admission. Review of the record revealed Resident # 10 had chosen not to execute an advance directive. Further review of the clinical record and the EHR failed to evidence documentation that Resident # 10 was provided periodic review to develop an advance directive.

On 06/26/19 at 4:40 p.m., an interview was conducted with OSM (othjer staff member) # 1, social worked and admissions coordinator. When asked if she had documentation that she had periodically reviewed advance directives with Resident #10 or the resident's responsible party, OSM # 1 stated no.

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) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain

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
F 578	Continued From page 34	F 578		

attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(3) 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.
6. The facility staff failed to review the Resident #17's wishes regarding advanced directives.

Resident #17 was admitted to the facility on 05/30/2007. Her diagnoses included hemiplegia (weakness of one side of the body) of the right dominant side, hypertension (high blood pressure), and heart failure (1). Resident #17's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 04/30/2019. The Brief Interview for Mental Status (BIMS) was not performed, as Resident #17 was coded as rarely or never understood.

A review of Resident #17's record was conducted on 06/25/2019. During review, documentation of an initial assessment of the resident's advanced directives, done upon admission, was located. However, periodic reassessment of the Resident's wishes regarding an advanced directive was not documented.

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
F 578	Continued From page 35	F 578		

An interview was conducted with other staff member (OSM) # 1, the social worker and admissions staff member, on 6/26/19 at 4:40 p.m. When asked how she goes over the advanced directive with the residents, OSM #1 stated, "I give the resident and/or resident representative information about formulating and advanced directive upon admission. She stated they go over a full code or a DNR (do not resuscitate). Even if they don't formulate an advanced directive, the form is on the chart." When asked where the periodic review of advanced directives is documented, OSM #1 stated, "I review the code status quarterly and again ask about an advanced directive." OSM #1 was asked to provide evidence of the discussion of the advanced directive and not the code status. OSM #1 stated she would like to get her computer. OSM #1 returned to the survey team and demonstrated where she documents on the assessment forms. According to what OSM #1 demonstrated on the computer, the box is labeled "advanced directive" and she documents in the box if the resident is a full code or DNR. When asked about what she was demonstrating, and if she is indicating if the resident has an advanced directive or not, OSM #1 stated, "I am not indicating if they have one or not." OSM #1 stated, "What you have is what I have."

Administrative Staff Member (ASM) #1, the Facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/26/2019. No further documentation was provided.

7. The facility staff failed to review Resident #35's

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
F 578	Continued From page 36	F 578		

wishes regarding advanced directives.

Resident #35 was admitted to the facility on 11/02/1025. Her diagnoses included hypertension, arthritis, and contracture of the leg. Resident #35's most recent MDS Assessment was a Quarterly Assessment with an ARD of 05/22/2019. The BIMS was not conducted, as Resident #35 was coded as rarely or never understood.

A review of Resident #35's record was conducted on 06/25/2019. During review, documentation of an initial assessment of the Resident's Advanced Directives, done upon admission, was located. However, periodic reassessment of the Resident's wishes regarding an Advanced Directive was not documented.

An interview was conducted with other staff member (OSM) # 1, the social worker and admissions staff member, on 6/26/19 at 4:40 p.m. OSM #1 was asked to provide evidence of the discussion of the advanced directive and not the code status. OSM #1 stated she would like to get her computer. OSM #1 returned to the survey team and demonstrated where she documents on the assessment forms. According to what OSM #1 demonstrated on the computer, the box is labeled "advanced directive" and she documents in the box if the resident is a full code or DNR. When asked about what she was demonstrating, and if she is indicating if the resident has an advanced directive or not, OSM #1 stated, "I am not indicating if they have one or not." OSM #1 stated, "What you have is what I have."

Administrative Staff Member (ASM) #1, the Facility Administrator, and ASM #2, the Director of

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
F 578	Continued From page 37 Nursing, were informed of the findings at the end of day meeting on 06/26/2019. No further documentation was provided. 8. The facility staff failed to review Resident #9's wishes regarding advanced directives. Resident #9 was admitted to the facility on 04/19/2011. Her diagnoses included heart failure and chronic kidney disease(2). Resident #9's most recent MDS Assessment was a Quarterly Assessment with an ARD of 04/15/2019. The BIMS scored Resident #9 at 11, indicating moderate impairment. A review of Resident #9's record was conducted on 06/25/2019. During review, documentation of an initial assessment of the resident's advanced directives, done upon admission, was located. However, periodic reassessment of the resident's wishes regarding an advanced directive was not documented. An interview was conducted with other staff member (OSM) # 1, the social worker and admissions staff member, on 6/26/19 at 4:40 p.m. OSM #1 was asked to provide evidence of the discussion of the advanced directive and not the code status. OSM #1 stated she would like to get her computer. OSM #1 returned to the survey team and demonstrated where she documents on the assessment forms. According to what OSM #1 demonstrated on the computer, the box is labeled "advanced directive" and she documents in the box if the resident is a full code or DNR. When asked about what she was demonstrating, and if she is indicating if the resident has an advanced directive or not, OSM #1 stated, "I am not indicating if they have one or not." OSM #1	F 578		

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
F 578	Continued From page 38	F 578		

stated, "What you have is what I have."

Administrative Staff Member (ASM) #1, the Facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/26/2019. No further documentation was provided.

9. The facility staff failed to review Resident #31's wishes regarding advanced directives.

Resident #31 was admitted to the facility on 10/28/2015. Her diagnoses included hypertension and chronic kidney disease. Resident #31's most recent MDS Assessment was a Quarterly Assessment with an ARD of 05/14/2019. The BIMS scored Resident #31 at an 11, indicating moderate impairment.

A review of Resident #31's record was conducted on 06/25/2019. During review, documentation of an initial assessment of the resident's advanced directives, done upon admission, was located. However, periodic reassessment of the resident's wishes regarding an advanced directive was not documented.

An interview was conducted with other staff member (OSM) # 1, the social worker and admissions staff member, on 6/26/19 at 4:40 p.m. She stated they go over a full code or a DNR (do not resuscitate). Even if they don't formulate an advanced directive, the form is on the chart." When asked where the periodic review is documented, OSM #1 stated, "I review the code status quarterly and again ask about an advanced directive." When asked to provide evidence of the discussion of the advanced directive, not the code status, OSM #1 stated she

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
F 578	Continued From page 39	F 578		

would like to get her computer. OSM #1 returned to the survey team and demonstrated where she documents on the assessment forms. When stated to OSM #1, which according to what she has demonstrated on the computer, the box is labeled "advanced directive" and she documents in the box if the resident is a full code or DNR. When stated that according to what she was demonstrating, she is not indicating if the resident has an advanced directive or not, OSM #1 stated, "I am not indicating if they have one or not." OSM #1 stated, "What you have is what I have."

Administrative Staff Member (ASM) #1, the Facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/26/2019. No further documentation was provided.

10. The facility staff failed to review the Resident #16's wishes regarding Advanced Directives.

Resident #16 was admitted to the facility on 01/18/2019. Her diagnoses included hyperlipidemia (high cholesterol), hypocalcemia (low calcium), hypertension (high blood pressure), and dementia. Resident #16's most recent Minimum Data Set (MDS) Assessment was a Quarterly Assessment with an ARD of 04/25/2019. The BIMS scored Resident #16 at a 3, indicating severe impairment.

A review of Resident #16's record was conducted on 06/25/2019. During review, documentation of an initial assessment of the resident's advanced directives, done upon admission, was located. However, periodic reassessment of the resident's wishes regarding an advanced directive was not documented.

RECEIVED
JUL 23 2019
VDH/OLC

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
F 578	Continued From page 40	F 578		

An interview was conducted with other staff member (OSM) # 1, the social worker and admissions staff member, on 6/26/19 at 4:40 p.m. She stated they go over a full code or a DNR (do not resuscitate). Even if they don't formulate an advanced directive, the form is on the chart." When asked where the periodic review is documented, OSM #1 stated, "I review the code status quarterly and again ask about an advanced directive." When asked to provide evidence of the discussion of the advanced directive, not the code status, OSM #1 stated she would like to get her computer. OSM #1 returned to the survey team and demonstrated where she documents on the assessment forms. When stated to OSM #1, which according to what she has demonstrated on the computer, the box is labeled "advanced directive" and she documents in the box if the resident is a full code or DNR. When stated that according to what she was demonstrating, she is not indicating if the resident has an advanced directive or not, OSM #1 stated, "I am not indicating if they have one or not." OSM #1 stated, "What you have is what I have."

Administrative Staff Member (ASM) #1, the Facility Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/26/2019. No further documentation was provided.

1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides

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 41 of the heart. - https://medlineplus.gov/heartfailure.html 2. Chronic kidney disease (CKD) means that your kidneys are damaged and can't filter blood as they should. This damage can cause wastes to build up in your body. It can also cause other problems that can harm your health. Diabetes and high blood pressure are the most common causes of CKD. - https://medlineplus.gov/chronickidneydisease.html 11. The facility staff failed to evidence documentation that a periodic review of advanced directives was conducted with Resident #11 and/or their resident representative. Resident #11 was admitted to the facility on 3/18/16 with diagnoses that included but were not limited to: stroke, pain, depression, high blood pressure, and COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)]. The most recent MDS (minimum data set) assessment, an annual assessment with an assessment reference date of 4/16/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. Review of the clinical record revealed documented, "Advanced Directive Acknowledgement" dated 7/13/17.	F 578		

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
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F 578	Continued From page 42	F 578		

The physician's orders dated, 10/23/17, documented, "Full code." (Full code is to provide CPR [cardiopulmonary resuscitation] in the event the resident's heart stops and/or they stop breathing).

Further review of the clinical record failed to evidence documentation of a periodic review of the resident's wishes regarding an advanced 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 advance directive." When asked if she had documentation that she had reviewed the advance directive with Resident #11 or the responsible party, OSM # 1 stated no.

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, 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

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
F 578	Continued From page 43	F 578		

Chapman, page 124.

12. The facility staff failed to evidence documentation that a periodic review was conducted with Resident #39 and/or their resident representative, of an advanced directive.

Resident #39 was admitted to the facility on 12/11/15 with diagnoses that included but were not limited to: diabetes, high blood pressure, and dementia. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 6/3/19, coded the resident with both short and long-term memory difficulties.

Review of the clinical record revealed documented, "Advanced Directive Acknowledgement" dated 12/18/15.

The physician order dated, 12/17/15, documented, "Full Code."

Further review of the clinical record failed to evidence documentation of a periodic review of the resident's wishes regarding an advanced 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.

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
F 578	Continued From page 44	F 578		

Continued From page 44

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 advance directive." When asked if she had documentation that she had reviewed the advance directive with Resident #39 or the responsible party, OSM # 1 stated no.

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 6/27/19 at 4:04 p.m.

No further information was provided prior to exit.

13. The facility staff failed to evidence documentation that a periodic review was conducted with Resident #42 and/or their resident representative, of an advanced directive.

Resident #42 was admitted to the facility on 1/8/02 with diagnoses that included but were not limited to: dementia, amputation of one leg above the knee, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/3/19, coded the resident as having both short and long-term memory difficulties and being moderately impaired to make daily cognitive decisions.

Review of the clinical record revealed documented, "Advanced Directive Acknowledgement" dated 4/11/08.

The physician order dated, 12/17/13,

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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
F 578	Continued From page 45	F 578		

documented, "DNR [do not resuscitate]."

Further review of the clinical record failed to evidence documentation of a periodic review of the resident's wishes regarding an advanced 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 advance directive." OSM #1 was asked to provide evidence of the discussion of the advanced directive and not the code status. OSM #1 stated she would like to get her computer. OSM #1 returned to the survey team and demonstrated where she documents on the assessment forms. According to what OSM #1 demonstrated on the computer, the box is labeled "advanced directive" and she documents in the box if the resident is a full code or DNR. When asked about what she was demonstrating, and if she is indicating if the resident has an advanced directive or not, OSM #1 stated, "I am not indicating if they have one or not." OSM #1 stated, "What you have is what I have."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing,

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
F 578	Continued From page 46	F 578		

were made aware of the above concern on 6/27/19 at 4:04 p.m.

No further information was provided prior to exit.

14. The facility staff failed to evidence documentation that a periodic review was conducted with Resident #38 and/or their resident representative, of an advanced directive.

Resident #38 was admitted to the facility on 7/19/13 with diagnoses that included but were not limited to: diabetes, high blood pressure, and depression. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/27/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she is capable of making daily cognitive decisions.

Review of the clinical record revealed documented, "Advanced Directive Acknowledgement" signed by the responsible party but there was no date on the form.The physician order dated, 3/14/19, documented, "DNR."

Further review of the clinical record failed to evidence documentation of a periodic review of the resident's wishes regarding an advanced 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.

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
F 578	Continued From page 47 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 advance directive." OSM #1 was asked to provide evidence of the discussion of the advanced directive and not the code status. OSM #1 stated she would like to get her computer. OSM #1 returned to the survey team and demonstrated where she documents on the assessment forms. According to what OSM #1 demonstrated on the computer, the box is labeled "advanced directive" and she documents in the box if the resident is a full code or DNR. When asked about what she was demonstrating, and if she is indicating if the resident has an advanced directive or not, OSM #1 stated, "I am not indicating if they have one or not." OSM #1 stated, "What you have is what I have." Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 6/27/19 at 4:04 p.m. No further information was provided prior to exit.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment 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	F 584	**F584** **Corrective Action(s):** An incident & Accident form was completed for not providing a homelike dining experience for residents #28, #13, #29, 9.	

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
F 584	Continued From page 48 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 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility	F 584	**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 homelike 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.	

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
F 584	Continued From page 49 staff failed to provide a homelike dining experience for four of forty residents in the survey sample, Residents #28, #13, #29 and #57. 1. The facility staff failed to provide a homelike dining experience for Resident #28, by hand feeding her in the hallway. 2. The facility staff failed to provide a homelike dining experience for Resident #13, by hand feeding her in the hallway. 3. The facility staff failed to provide a homelike dining experience for Resident #29, by hand feeding her in the hallway. 4. The facility staff fed Resident # 57 in the hallway, failing to provide a homelike dining experience. The findings include: 1. The facility staff failed to provide a homelike dining experience for Resident #28, by hand feeding her in 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	F 584	**Monitoring:** The DON and Administrator are responsible for compliance. The DON, unit managers 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**	

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

F 584 Continued From page 50 | F 584

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 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

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
F 584	Continued From page 51	F 584		

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." When asked if feeding a resident in the hallway providing a dining experience, ASM #2 stated, "People would still be watching them in the dining room." When asked as a reasonable person, would you want to be fed in the hallway, ASM #2 stated, "I would want to be asked."

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
F 584	Continued From page 52 The facility policy, "Quality of Life - Homelike Environment" documented in part, "Residents are provided with a safe, clean, comfortable and homelike environment and encourage to use their personal belongings to the extent possible. 1. Staff shall provide person-centered care that emphasizes the resident's comfort, independence, and personal needs and preferences....3. The facility staff and management shall minimize, to the extent possible, the characteristic of the facility that reflect a depersonalized, institutional setting." 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 a homelike dining experience for Resident #13, by hand feeding her in 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 esophagus, commonly known as heartburn (1)]. The most recent MDS (minimum data set) Assessment, an annual assessment, with an	F 584		

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JUL 23 2019
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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
F 584	Continued From page 53	F 584		

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 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

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

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F 584	Continued From page 54	F 584		

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." When asked if feeding a resident in the hallway

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 584	Continued From page 55	F 584		

providing a dining experience, ASM #2 stated, "People would still be watching them in the dining room." When asked as a reasonable person, would you want to be fed in the hallway, ASM #2 stated, "I would want to be asked."

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 a homelike dining experience for Resident #29, by hand feeding her in 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).

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

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
F 584	Continued From page 56	F 584		

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, 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

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
F 584	Continued From page 57 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." When asked if feeding a resident in the hallway providing a dining experience, ASM #2 stated, "People would still be watching them in the dining room." When asked as a reasonable person, would you want to be fed in the hallway, ASM #2 stated, "I would want to be asked."	F 584		

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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
F 584	Continued From page 58	F 584		

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 fed Resident # 57 in the hallway, failing to provide a homelike dining experience.

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.

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

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
F 584	Continued From page 59	F 584		

(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." ASM #2 was 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 it." When asked if eating in the hallway provided a dining experience, ASM # 2 stated no.

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

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JUL 23 2019
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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
F 584	Continued From page 60 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 able to ambulate independently and safely. This information was obtained from the website: http://www.merrywalker.com/mw-product-detail-home-care-walker.html.	F 584		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an	F 641	**F641** **Corrective Action(s):** Resident #16 has had their most recent MDS modified to accurately code section I and to remove the active diagnosis of Psychosis. Resident #16's comprehensive care plan has been reviewed and revised to include removing the diagnoses of psychosis. 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
	495317	A. BUILDING ______ B. WING ______	C 06/27/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 641

Continued From page 61

accurate Minimum Data Set assessment for one of 40 sampled residents, Resident #16. The facility staff incorrectly coded Resident #16's Minimum Data Set (MDS) assessment with the diagnosis of Psychotic Disorder (other than schizophrenia).

The findings include:

Resident #16 was admitted to the facility on 01/18/2019. Her diagnoses included hyperlipidemia (high cholesterol), hypocalcemia (low calcium), hypertension (high blood pressure), and dementia. Resident #16's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an ARD (assessment reference date) of 04/25/2019. The BIMS scored Resident #16 as a 3, indicating severe impairment. Resident #16 was coded as requiring supervision and setup assistance for dining, and requiring extensive assistance of 1 person for all other ADLs (activities of daily living). In Section I - Active Diagnoses, "Psychotic Disorder (other than schizophrenia)" was marked "checked".

When reviewing Resident #16's list of diagnoses on the facility's Electronic Health Record, no diagnosis of a mental illness was found.

On 06/27/19, 10:22 AM an interview was conducted with Registered Nurse (RN) #1, the MDS Coordinator. RN #1 was asked why Resident #16's MDS reflected a Psychotic Disorder, but that diagnosis was not present on her facility diagnosis list. RN #1 stated that any resident who is admitted with "dementia with behaviors" and is being treated for such with

F 641

Identification of Deficient Practice(s) and Corrective Action(s):
All other residents may have potentially been affected. A 100% audit of all residents current MDS assessments will be completed by the RCC and/or designee to ensure that sections I of the MDS are coded correctly. All negative findings will be reported to the MDS department for immediate correction. A Modification will be completed for each discrepancy identifiedon the most current MDS.

Systemic Change(s):
The Resident Interdisciplinary Care Team has been inserviced by the Regional Nurse consultant on the proper assessment and coding of all sections of the MDS. All comprehensive MDS's and quarterly MDS's will now be reviewed each week according to the MDS schedule by the RCC and/or DON to ensure the accuracy and integrity of resident data.

Monitoring:
The DON and RCC are responsible for monitoring compliance. The MDS assessment audit will be completed weekly coinciding with the MDS calendar to monitor for compliance. All negative findings from the audits will be reported to the DON and RCC at the time of discovery for immediate correction. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, andrecommendations for change in facility policy, procedure, and/or practice.
Completion Date: 08/10/2019

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 641 Continued From page 62 F 641

antipsychotic medication, will have "psychotic disorder (other than schizophrenia)" marked on their MDS Section I. RN #1 stated that Resident #16 had improved and was no longer being treated with antipsychotic medications. RN #1 was asked what instructions they followed to code the MDS Assessment. She stated that they follow the Resident Assessment Instrument (RAI) Manual. RN #1 was asked to provide evidence that coding a Resident taking an anti-psychotic medication as having a diagnosis of psychosis was correct.

On the morning of 06/27/2019, RN #1 provided this surveyor with an email from the facility's pharmacy provider, with information on the Antipsychotic drug Seroquel (1). The email listed among "off-label" uses for Seroquel treatment of "behavioral and psychological symptoms of dementia". RN #1 did not provide any documentation to support the practice of coding a resident taking an antipsychotic medication as having a diagnosis of psychosis.

A review of Resident #16's Physician Orders did not reveal any orders for antipsychotic medications.

Administrative Staff Member (ASM) #1, the Administrator, and ASM #2, the Director of Nursing, were informed of the findings at the end of day meeting on 06/27/2019. No further documentation was provided.

F 656 SS=E Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) F 656

§483.21(b) Comprehensive Care Plans
§483.21(b)(1) The facility must develop and

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JUL 23 2019
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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 656	Continued From page 63 implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.	F 656	**F656** **Corrective Action(s):** Resident #53's Oxygen order has been clarified with the attending physician and their comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include using physician ordered oxygen. A Facility Incident & Accident Form was completed for this incident. Resident #48's pain medication orders have been clarified with the attending physician and their comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include administer pain medication per physician order. A Facility Incident & Accident Form was completed for this incident. Resident #37's comprehensive care plan has been reviewed and revised to reflect the current goals and interventions and approaches to address the resident's specific medical and treatment needs to include the maintaining resident 37's call bell within his reach for use in notifying staff. A Facility Incident & Accident Form was completed for this incident. Resident #58's comprehensive care plan has been reviewed and revised to reflect appropriate goals and interventions and approaches to address the resident's specific medical and treatment needs to include the use of non-pharmacological interventions prior to the use of pain medications. 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
	495317	A. BUILDING _____ B. WING _____	C 06/27/2019

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HERITAGE HALL DILLWYN	119 BRICKYARD DRIVE DILLWYN, VA 23936

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F 656

Continued From page 64

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 implement the comprehensive care plan for four of 40 residents in the survey sample, Residents #11, #48, #37 and #58.

The findings include:

1. The facility staff failed to implement Resident #11's comprehensive care plan for the administration of oxygen.

Resident #11 was admitted to the facility on 3/18/16 with diagnoses that included but were not limited to: stroke, pain, depression, high blood pressure, and COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)].

The most recent MDS (minimum data set) assessment, an annual assessment with an assessment reference date of 4/16/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive decisions. The resident was coded as requiring supervision to extensive assistance of one or more staff members for all of his activities of daily living. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as using oxygen while a resident at the facility.

F 656

Identification of Deficient Practices & Corrective Action(s):
All residents may have potentially been affected. A 100% review of all comprehensive care plans will be conducted by the DON, ADON, RCC and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A Facility Incident & Accident Form will be completed for each incident identified.

Systemic Changes:
The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The nursing assessment process as evidenced by the 24 Hours Report and documentation in the medical record and physician orders will be used to develop and revise comprehensive plans of care. The nursing staff will be inserviced by the DON and/or regional nurse consultant on the development, revision and implementation and following of individualized resident care plans. This will include C.N.A. Closet care plans.

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
F 656	Continued From page 65 The comprehensive care plan dated, 4/17/19, documented in part, "Problem: (Resident #11) has COPD, is at risk for ineffective tissue perfusion, oxygenation, pulmonary related." The "Approaches" documented in part, "Oxygen as ordered." Observation was made of Resident #11 during the initial screening on 6/25/19 at approximately 1:00 p.m. The resident was observed sitting up in his wheelchair with his oxygen on via a nasal cannula (a plastic two with two prongs that inserts into the nose) connected to an oxygen concentrator. The oxygen concentrator was set with the bottom of the ball on zero and the top of the ball on the 0.5 LPM (liters per minute) line. The resident was again observed with the oxygen in use on 6/26/19 at 8:05 a.m. The oxygen was set with the bottom of the ball on the zero and the top of the ball sitting on 0.5 LPM. A third observation was made on 6/26/19 at 3:41 p.m. The resident was sitting up in his wheelchair, his oxygen was in use and set with the top of the ball sitting on the zero line and the top of the ball sitting on the 0.5 LPM line. An interview was conducted with LPN (licensed practical nurse) #3 on 6/26/19 at 3:45 p.m. When asked how you read the oxygen concentrator, LPN #3 stated, "On the gauge, the line goes through the middle of the ball." LPN #3 was asked if she was aware of Resident #11's order for oxygen. LPN #3 verified the order and stated, "It's supposed to be on 2 LPM." LPN #3 checked the resident's pulse ox (percentage of oxygen in the blood stream) and it was 91%. LPN #3 asked Resident #11 if he adjusted the knob on the oxygen concentrator and he stated, "No."	F 656	**Monitoring:** The RCC and DON are responsible for maintaining compliance. The DON and/or RCC will perform care plan audits weekly coinciding with the care plan calendar to monitor for compliance. Any/all negative findings will be reported to the DON / RCC for immediate correction. Detailed findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 08/10/2019**	

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
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F 656	Continued From page 66	F 656		

The physician order dated, 7/13/17, documented, "O2 (oxygen) NC (nasal cannula) @ 2 L (liters) for O2 sats (saturation) < (less than) 90."

An interview was conducted with LPN #2 on 6/27/19 at 10:38 a.m. When asked the purpose of the comprehensive care plan, LPN #2 stated, "It's to make sure we have proper care of the patient, there are things to ensure they get the proper care, medications, and treatments, anything we can do to improve their quality of life. It's individualized for each patient."

The facility policy, "Care Plans, Comprehensive Person-Centered." documented in part, "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident."

Administrative staff member (ASM) #1, the administrator, was made aware of the above findings on 6/26/19 at 6:00 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 124.

2. The facility staff failed to implement Resident #48's comprehensive care plan for the treatment of pain.

Resident #48 was admitted to the facility on 5/31/19 with diagnoses that included but were not limited to: high blood pressure, diabetes, atrial fibrillation [a condition characterized by rapid and

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
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F 656	Continued From page 67	F 656		

Continued From page 67
random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria.(1)], injuries obtained in a motor-vehicle accident, and a broken fibula.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/14/19, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) scoring, indicating he was capable of making daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of his activities of daily living. In Section J - Health Conditions, the resident was coded as having occasional pain that is moderate in intensity.

The comprehensive care plan dated, 6/12/19, documented in part, "Problem: (Resident #48) needs assist with his ADLs (activities of daily living) due to weakness and pain from fractures sustained in a MVA (motor vehicle accident)...He is at risk for unrelieved pain." The "Approaches" documented in part, "Monitor for pain. Tx (treatments) as ordered. Note the desired pain relief and for adverse side effects. Use non-pharmacological methods along with the meds (medications) to Max (maximize) pain relief."

The physician order dated, 6/5/19, documented, "Oxycodone [used to treat moderate to severe pain (2)] 5 mg (milligram) tablet; give 1/2 (2.5 mg) tablet, PO (by mouth) Q (every) 4 H (hours) PRN (as needed) for moderate pain. Scale 5-7."

The physician order dated, 6/5/19 documented,

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 656	Continued From page 68	F 656		

"Oxycodone 5 mg tablet; give 1 tablet PO Q4H PRN for severe pain. Scale 8 - 10."

Review of the MAR (medication administration record) documented both of the physician's orders above.
On 6/12/19 at 12:28 a.m., the nurse administered the half tablet of Oxycodone for a pain level of "8." On 6/21/19 at 7:48 a.m. the nurse, (LPN [licensed practical nurse] #2) administered the whole tablet for a pain level of "7."

An interview was conducted with LPN #2 on 6/27/19 at 10:38 a.m. The above two orders were reviewed with LPN #2. The above MAR documenting on 6/12/19 that a 1/2 tablet of Oxycodone was given for a pain level of "8" was reviewed with LPN #2. When asked if that was following the physician's order, LPN #2 stated, "No, Ma'am." The documentation on the MAR on 6/21/19 evidencing of a whole tablet of Oxycodone was given for a pain level of 7 was reviewed with LPN #2. LPN #2 stated, "He was one number away from getting the whole tablet. I should have only given the half tablet." When asked the purpose of the care plan, LPN #2 stated, "It's to make sure we have proper care of the patient, there are things to ensure they get the proper care, medications, and treatments, anything we can do to improve their quality of life. It's individualized for each patient." When asked since the medication was not given as ordered, is that following the care plan, LPN #2 stated, "No, Ma'am."

Administrative staff member (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concerns on 6/27/19 at 4:04 p.m.

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 656	Continued From page 69	F 656		

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 55.
(2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html

3. The facility staff failed to implement Resident # 37's care plan for the call bell to be within reach.

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" coded Resident # 37 as having "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

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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
F 656	Continued From page 70	F 656		

Continued From page 70

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 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."

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
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F 656	Continued From page 71	F 656		

An interview was conducted with LPN #2 on 6/27/19 at 10:38 a.m. When asked the purpose of the care plan, LPN #2 stated, "It's to make sure we have proper care of the patient, there are things to ensure they get the proper care, medications, and treatments, anything we can do to improve their quality of life. It's individualized for each patient."

On 06/02/19 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.

(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:

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
F 656	Continued From page 72	F 656		

https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

4. The facility staff failed to implement Resident # 58's care plan for the use of non-pharmacological interventions prior to the administration of PRN (as needed) pain medication.

Resident # 58 was admitted to the facility on 06/12/2019 with diagnoses that included but were not limited to: osteoarthritis (1), chronic obstructive pulmonary disease (2) and gastroesophageal reflux disease (3).

Resident # 58's most recent MDS (minimum data set), a admission assessment with an ARD (assessment reference date) of 06/19/19, coded Resident # 58 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 # 58 was coded as requiring limited assistance of one staff member for all activities of daily living. Section "J0600 Pain Intensity. Ask resident "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine" coded Resident # 58 as "2 (two) Moderate."

On 06/26/19 at approximately 4:09 p.m., during the medication administration observation with LPN (licensed practical nurse) # 4, Resident # 58 was observed receiving prn (as needed) pain medication. After LPN # 4 administered Resident # 58's scheduled medication Resident # 58 verbally stated to LPN # 4 that she was having pain. LPN # 4 asked Resident # 58 where her pain was and what level of pain she was experiencing on a scale from zero to ten, with ten

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
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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 656	Continued From page 73	F 656		

being the most severe. Resident # 58 stated, "It's an eight." LPN # 4 was observed going to the mediation cart, and looking up the physician's order for prn pain medication for Resident # 58. LPN #4 then dispensed two tablets of Hydrocodone/5-325mg (milligram) (4), and administered the medication to Resident # 58 with a small glass of water. Resident # 58 was observed consuming the medication. Further observation of this medication administration failed to evidence LPN # 4 attempting or offering non-pharmacological interventions before administering the hydrocodone.

The POS (physician's order sheet) dated "June 2019" for Resident # 58 documented, "NORCO 5-325 TABLET. Give 2 (two) tablets PO (by mouth) Q4H (every four hours) for pain (Scale 6-10). Generic: HYDROCODONE. Order Date: 6/12/19."

The eMAR (electronic administration record) for Resident # 58 dated "June 2019" documented, "NORCO 5-325 TABLET. Give 2 tablets PO Q4H for pain (Scale 6-10)." Further review of the eMAR documented the administration of NORCO (hydrocodone) to Resident # 58 on 06/26/19 with a pain level of eight.

The comprehensive care plan for Resident # 58 dated 06/21/19 documented, "Problem/Need. (Resident # 58 needs assist (assistance) with her ADLs due to hx (history) Polio and recent hip replacement surgery due to DJD (degenerative joint disease). She is at risk for falls and skin breakdown due to poor mobility, unsteady gait. She is at risk for pain r/t (related to) medical dxs (diagnoses) polio and recent surgery rt (right) hip replacement r/t DJD, spinal laminectomy.

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
F 656	Continued From page 74	F 656		

Resident has incision line on her left hip that requires tx (treatment). Resident at risk for a decline in her continence pattern due to weakness, pain, poor mobility. Res (resident) is cont (continent) bowel and bladder." Under "Approaches", it documented in part, "Resident to be monitored for pain. Treat as ordered. Noted the desired pain relief and for adverse side effects. Use nonpharmacological methods of pain relief along with meds (medications) to max (maximize) the pain relief benefit."

On 06/26/19 at 5:11 p.m. an interview was conducted with LPN # 4. When asked if she attempted or asked Resident # 58 about trying to alleviate her pain before administering the pain medication LPN # 4 stated, "No I should have."

An interview was conducted with LPN #2 on 6/27/19 at 10:38 a.m. When asked the purpose of the comprehensive care plan, LPN #2 stated, "It's to make sure we have proper care of the patient, there are things to ensure they get the proper care, medications, and treatments, anything we can do to improve their quality of life. It's individualized for each patient."

On 06/02/19 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) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information

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JUL 23 2019
VDH/OLC

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
F 656	Continued From page 75 was obtained from the website: https://medlineplus.gov/osteoarthritis.html. (2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html. (3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html. (4) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone. The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website: https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.	F 656		
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 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 684	**F684** **Corrective Action(s):** Resident #48's attending physician was notified that the facility staff failed to administer the pain medication Oxycodone as ordered by the physician. A facility Medication Error 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
	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

F 684

Continued From page 76

was determined the facility staff failed to ensureensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, for one of 40 residents in the survey sample, Residents #48.

The findings include:

The facility staff failed to administer pain medications to Resident #48 per the physician's orders on 6/21/19.

Resident #48 was admitted to the facility on 5/31/19 with diagnoses that included but were not limited to: high blood pressure, diabetes, atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria.(1)], injuries obtained in a motor-vehicle accident, and a broken fibula.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/14/19, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) scoring, indicating he was capable of making daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one or more staff members for all of his activities of daily living. In Section J - Health Conditions, the resident was coded as having occasional pain that is moderate in intensity.

The comprehensive care plan dated, 6/12/19, documented in part, "Problem: (Resident #48)

F 684

Identification of Deficient Practices/Corrective Action(s):
All other residents receiving physician ordered pain medication may have potentially been affected. The DON, ADON, and Unit Managers will conduct a 100% audit of all resident's physician order pain medications 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 completing physician medication and treatment orders as ordered by the physician.

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
F 684	Continued From page 77	F 684		

needs assist with his ADLs (activities of daily living) due to weakness and pain from fractures sustained in a MVA (motor vehicle accident)...He is at risk for unrelieved pain." The "Approaches" documented in part, "Monitor for pain. Tx (treatments) as ordered. Note the desired pain relief and for adverse side effects. Use non-pharmacological methods along with the meds (medications) to Max (maximize) pain relief."

The physician order dated, 6/5/19, documented, "Oxycodone [used to treat moderate to severe pain (2)] 5 mg (milligram) tablet; give 1/2 (2.5 mg) tablet, PO (by mouth) Q (every) 4 H (hours) PRN (as needed) for moderate pain. Scale 5-7."

The physician order dated, 6/5/19 documented, "Oxycodone 5 mg tablet; give 1 tablet PO Q4H PRN for severe pain. Scale 8 - 10."

Review of the MAR (medication administration record) documented both of the physician's orders above.
On 6/12/19 at 12:28 a.m., the nurse administered the half tablet of Oxycodone for a pain level of "8." On 6/21/19 at 7:48 a.m. the nurse, (LPN [licensed practical nurse] #2) administered the whole tablet for a pain level of "7."

An interview was conducted with LPN #2 on 6/27/19 at 10:38 a.m. The above two orders were reviewed with LPN #2. The above MAR documenting on 6/12/19 that a 1/2 tablet of Oxycodone was given for a pain level of "8" was reviewed with LPN #2. When asked if that was following the physician's order, LPN #2 stated, "No, Ma'am." The documentation on the MAR for 6/21/19 evidencing of a whole tablet of

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: 08/10/2019

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F 684	Continued From page 78	F 684		

Oxycodone was given for a pain level of 7 was reviewed with LPN #2. LPN #2 stated, "He was one number away from getting the whole tablet. I should have only given the half tablet."

The facility policy, "Administering Pain Medications" documented in part, "Purpose: The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication...3. Conduct a pain assessment as indicated...Evaluate and document the effectiveness of non-pharmacologic interventions (e.g., repositioning, warm or cold compresses, etc.)...Administer pain medications as ordered."

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc.; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

Administrative staff membe3r (ASM) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concerns 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 55.
(2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html

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F 695 Continued From page 79

F 695 SS=D

Respiratory/Tracheostomy Care and Suctioning
CFR(s): 483.25(i)

§ 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning.
The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide oxygen per the physician order for one of 40 residents in the survey sample, Resident #11.
The facility staff failed to administer Resident #11's oxygen per the physician's order.

The findings include:

Resident #11 was admitted to the facility on 3/18/16 with diagnoses that included but were not limited to: stroke, pain, depression, high blood pressure, and COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)].

The most recent MDS (minimum data set) assessment, an annual assessment with an assessment reference date of 4/16/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating he was severely impaired to make daily cognitive

F 695

F695

Corrective Action(s)
Resident #11's attending physician has been notified that the facility failed to ensure oxygen was administered as ordered by the physician. A Facility Incident & Accident form was completed for this incident.

Identification of Deficient Practice & Corrective Action(s):
All other resident receiving physician ordered oxygen may have potentially been affected. A 100% review of all residents with physician ordered oxygen was conducted to identify any/all residents at risk. Any negative findings were corrected at time of discovery. A facility Incident & Accident form will be completed for each negative finding.

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing staff will be inserviced by the DON on the proper procedure for administering oxygen per physician order.

Monitoring:
The DON and/or Unit Manager is responsible for maintaining compliance. The DON or Unit Manager will make weekly rounds to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. All negative 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: 08/10/2019

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F 695	Continued From page 80	F 695		

decisions. The resident was coded as requiring supervision to extensive assistance of one or more staff members for all of his activities of daily living. In Section O - Special Treatments, Procedures, and Programs, the resident was coded as using oxygen while a resident at the facility.

Observation was made of Resident #11 during the initial screening on 6/25/19 at approximately 1:00 p.m. The resident was observed sitting up in his wheelchair with his oxygen on via a nasal cannula (a plastic two with two prongs that inserts into the nose) connected to an oxygen concentrator. The oxygen concentrator was set with the bottom of the ball on zero and the top of the ball on the 0.5 LPM (liters per minute) line. The resident was again observed with the oxygen in use on 6/26/19 at 8:05 a.m. The oxygen was set with the bottom of the ball on the zero and the top of the ball sitting on 0.5 LPM. A third observation was made on 6/26/19 at 3:41 p.m. The resident was sitting up in his wheelchair, his oxygen was in use and set with the top of the ball sitting on the zero line and the top of the ball sitting on the 0.5 LPM line.

An interview was conducted with LPN (licensed practical nurse) #3 on 6/26/19 at 3:45 p.m. When asked how you read the oxygen concentrator, LPN #3 stated, "On the gauge, the line goes through the middle of the ball." LPN #3 was asked if she was aware of Resident #11's order for oxygen. LPN #3 verified the order and stated, "It's supposed to be on 2 LPM." LPN #3 checked the resident's pulse ox (percentage of oxygen in the blood stream) and it was 91%. LPN #3 asked Resident #11 if he adjusted the knob on the oxygen concentrator and he stated, "No."

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F 695	Continued From page 81	F 695		

The physician order dated, 7/13/17, documented, "O2 (oxygen) NC (nasal cannula) @ [at] 2 L (liters) for O2 sats (saturation) < (less than) 90."

The comprehensive care plan dated, 4/17/19, documented in part, "Problem: (Resident #11) has COPD, is at risk for ineffective tissue perfusion, oxygenation, pulmonary related." The "Approaches" documented in part, "Oxygen as ordered."

The facility policy, ""Oxygen Administration" documented in part, "Steps in the Procedure: 8. Turn on the oxygen. Unless otherwise ordered, start the flow of oxygen at the rate of 2 to 3 liters per minute...13. Observe the resident upon setup and periodically thereafter to be sure oxygen is being tolerated."

The manufacturer's instructions for the oxygen concentrator documented in part, "5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line marking the specific flow rate."

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

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F 695	Continued From page 82 Administrative staff member (ASM) #1, the administrator, was made aware of the above findings on 6/26/19 at 6:00 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 124.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure that pain management is provided consistent with professional standards of practice, and the comprehensive person-centered care plan for one of 40 residents in the survey sample, Resident #58. The facility staff failed to implement non-pharmacological interventions prior to the administration of as needed pain medication to Resident #58. The findings include: Resident # 58 was admitted to the facility on 06/12/2019 with diagnoses that included but were not limited to: osteoarthritis (1), chronic obstructive pulmonary disease (2) and	F 697	**F697** **Corrective Action(s):** Resident #58's attending physicians was notified that the facility failed to attempt non-pharmacological interventions prior to the administration of PRN hydrocodone for pain. A facility Incident and Accident form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving PRN pain medications may have been potentially affected. The DON, ADON, and/or Unit Manager will conduct a 100% audit of all resident's receiving PRN pain medications to identify resident at risk for not having non-pharmacological interventions attempted prior to administration of PRN pain medication. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 697	Continued From page 83 gastroesophageal reflux disease (3). Resident # 58's most recent MDS (minimum data set), a admission assessment with an ARD (assessment reference date) of 06/19/19, coded Resident # 58 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 # 58 was coded as requiring limited assistance of one staff member for all activities of daily living. Section "J0600 Pain Intensity. Ask resident "Please rate your worst pain over the last 5 days on a zero to ten scale, with zero being no pain and ten as the worst pain you can imagine" coded Resident # 58 as "2 (two) Moderate." On 06/26/19 at approximately 4:09 p.m., during the medication administration observation with LPN (licensed practical nurse) # 4, Resident # 58 was observed receiving prn (as needed) pain medication. After LPN # 4 administered Resident # 58's scheduled medication Resident # 58 verbally stated to LPN # 4 that she was having pain. LPN # 4 asked Resident # 58 where her pain was and what level of pain she was experiencing on a scale from zero to ten, with ten being the most severe. Resident # 58 stated, "It's an eight." LPN # 4 was observed going to the mediation cart, and looking up the physician's order for prn pain medication for Resident # 58. LPN #4 then dispensed two tablets of Hydrocodone/5-325mg (milligram) (4), and administered the medication to Resident # 58 with a small glass of water. Resident # 58 was observed consuming the medication. Further observation of this medication administration failed to evidence LPN # 4 attempting or offering non-pharmacological interventions before	F 697	**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 completing physician medication orders & treatment orders. This includes assessing the location of a resident's pain and attempting non-pharmacological interventions prior to (PRN) pain medication administration. The DON and/or Regional nurse consultant will inservice all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. As well as performing nonpharmacological interventions prior to administration of PRN pain medication. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform weekly 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: 08/10/2019**	

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F 697	Continued From page 84 administering the hydrocodone. The POS (physician's order sheet) dated "June 2019" for Resident # 58 documented, "NORCO 5-325 TABLET. Give 2 (two) tablets PO (by mouth) Q4H (every four hours) for pain (Scale 6-10). Generic: HYDROCODONE. Order Date: 6/12/19." The eMAR (electronic administration record) for Resident # 58 dated "June 2019" documented, "NORCO 5-325 TABLET. Give 2 tablets PO Q4H for pain (Scale 6-10)." Further review of the eMAR documented the administration of NORCO (hydrocodone) to Resident # 58 on 06/26/19 with a pain level of eight. The comprehensive care plan for Resident # 58 dated 06/21/19 documented, "Problem/Need. (Resident # 58 needs assist (assistance) with her ADLs due to hx (history) Polio and recent hip replacement surgery due to DJD (degenerative joint disease). She is at risk for falls and skin breakdown due to poor mobility, unsteady gait. She is at risk for pain r/t (related to) medical dxs (diagnoses) polio and recent surgery rt (right) hip replacement r/t DJD, spinal laminectomy. Resident has incision line on her left hip that requires tx (treatment). Resident at risk for a decline in her continence pattern due to weakness, pain, poor mobility. Res (resident) is cont (continent) bowel and bladder." Under "Approaches", it documented in part, "Resident to be monitored for pain. Treat as ordered. Noted the desired pain relief and for adverse side effects. Use nonpharmacological methods of pain relief along with meds (medications) to max (maximize) the pain relief benefit."	F 697		

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F 697	Continued From page 85	F 697		

On 06/26/19 at 5:11 p.m. an interview was conducted with LPN # 4. When asked if she attempted or asked Resident # 58 about trying to alleviate her pain before administering the pain medication LPN # 4 stated, "No I should have."

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) The most common form of arthritis. It causes pain, swelling, and reduced motion in your joints. It can occur in any joint, but usually it affects your hands, knees, hips or spine. This information was obtained from the website: https://medlineplus.gov/osteoarthritis.html.

(2) Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

(3) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

(4) Hydrocodone is an opioid pain medication. An opioid is sometimes called a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of hydrocodone.
The combination of acetaminophen and hydrocodone is used to relieve moderate to severe pain. This information was obtained from the website:

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

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F 697	Continued From page 86 https://www.rxlist.com/norco-5-325-drug/patient-images-side-effects.htm.	F 697		
F 700 SS=E	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. 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 complete assessments for the use of bed rails for nine of 40 residents in the survey sample, Residents #40, #10, #54, #48, #42, #23, #17, #35 and #26.	F 700	**F700** **Corrective Action(s):** Residents #40, #10, #54, #48, #42, #23, #17, #35, & #26 have been reassessed by nursing for the use of half side rails for mobility and repositioning. The residents comprehensive care plan has been revised to reflect the current use of side rails while in bed for mobility and repositioning. A Risk Management I&A form was completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** -All other residents using half side rails while in bed may have potentially been affected. Nursing and/or rehab will conduct a 100% audit of all residents who require the use of half side rails to ensure they have been properly assessed for the use of side rails and that they are being used appropriately to meet the resident's current safety and mobility needs. The residents identified will have their comprehensive plans of care revised to address the alarm use and wear schedule. Any/all negative finding will be corrected at the time of discovery. **Systemic Change(s):** Facility policy & procedure has been reviewed and no revisions are warranted at this time. Nursing Administration and/or the therapy department will inservice nursing staff on the proper side rail assessment and use of side rails to ensure they are being appropriately applied and used in accordance with the resident's plan of care.	

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

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HERITAGE HALL DILLWYN	119 BRICKYARD DRIVE DILLWYN, VA 23936

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F 700	Continued From page 87 The findings include: 1. The facility staff failed to assess Resident #40 for the use of bed rails prior to installation/use. Resident # 40 was admitted to the facility on 08/31/18 with diagnoses that included but were not limited to bipolar disorder (1), and gastroesophageal reflux disease, (2). Resident # 40's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 06/03/18, coded Resident # 40 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 # 40 was coded as being totally dependent of one staff member for all activities of daily living. The clinical record and the EHR (electronic health record) for Resident # 10 failed to evidence an assessment for the use of bed rails. The comprehensive care plan for Resident # 40 with a revision on 09/05/2018 documented, "Approaches: ½ (half) side rails up bilaterally to promote independent mobility and to define the parameters of the bed. Onset Date: 09/05/2018." On 6/25/19 at 3:44 p.m., Resident # 40 was observed in bed. Bilateral quarter bed rails were observed on the upper portion of the bed and were in the raised position. On 06/26/19, an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails, ASM # 2 stated that they did not have assessments for the use of	F 700	**Monitoring:** The DON is responsible for maintaining compliance. Side rails assessments will be completed and reviewed quarterly coinciding with the MDS/Care plan schedule to ensure they are still an appropriate intervention for each resident using them. The resident's comprehensive assessment will be revised and updated with any/all changes recommended. **Completion Date: 08/10/2019**	

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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
F 700	Continued From page 88	F 700		

bed rails.

The facility's policy "Proper Use Of Side Rails" documented, "3. An assessment will be made to determine the resident's symptoms, risk of entrapment and reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's" Bed mobility; Ability to change positions, transfer to and from bed or chair, and to stand and toilet; Risk of entrapment from the use of side rails; and That the beds dimensions are appropriate for the resident's size and weight."

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 above 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) Stomach contents to leak back, or reflux, into the esophagus and irritate it. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/gerd.html.

2. The facility staff failed to assess Resident #10 for the use of bed rails prior to installation/use.

Resident # 10 was admitted to the facility on

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
F 700	Continued From page 89	F 700		

05/17/2010 and a readmission on 05/15/2017 with diagnoses that included but were not limited to cerebral infarction (1), anxiety (2) and dementia (3).

Resident # 10's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 04/15/19 coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, two being moderately impaired of cognition for daily decision-making. Resident # 10 was coded as requiring extensive assistance of one staff member for activities of daily living and independent with eating.

The clinical record and the EHR (electronic health record) for Resident # 10 failed to evidence an assessment for the use of bed rails.

The comprehensive care plan for Resident # 10 with a revision on 04/17/2019 documented, "Approaches: Side rails ½ (half) rails up whenever resident is in bed. Onset Date: 04/17/2019."

On 6/25/19 at 3:55 p.m., Resident # 10 was observed in bed. Bilateral quarter bed rails were observed on the upper portion of the bed and were in the raised position.

On 06/26/19 an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails ASM # 2 stated that they did not have assessments for the use of bed rails.

On 06/27/19 at approximately 5:00 p.m., ASM

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
F 700	Continued From page 90	F 700		

(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 stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm .

(2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary.

(3) 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.

3. The facility staff failed to complete an assessment for Resident #54's use of side rails prior to installation/use.

Resident #54 was admitted to the facility on 5/20/19 with diagnoses that included but were not limited to: atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1), depression, wound in the groin, and history of

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
F 700	Continued From page 91	F 700		

a heart attack.

The most recent MDS (minimum data set) assessment, a Medicare 30 day assessment, with an assessment reference date of 6/15/19, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was cognitively intact to make daily decisions. In Section G - Functional Status, the resident was coded as requiring limited assistance of one staff member for moving in the bed.

The clinical record failed to evidence an assessment for the use of bed rails for Resident #54.

The comprehensive care plan, documented in part, "Problem: (Resident #54) requires assist with her ADLs (activities of daily living) due to weakness, pain, poor mobility from recent groin wound with infection." The "Approach" documented in part, "1/2 side rails up bilaterally to define the parameters of the bed and to promote independent bed mobility."

06/26/19 at 8:25 a.m., Resident # 54 was observed in bed with both the upper side rails up. When asked if she uses them, Resident #54 stated, "I use them to assist me to move in the bed." When asked if she signed a consent that documented the risks of using side rails, Resident #54 stated yes she had.

On 06/26/19, an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails ASM # 2 stated that they did not have assessments for the use of

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
F 700	Continued From page 92	F 700		

bed rails.

Administrative staff member (ASM) #1, the administrator, was made aware of the above concern on 6/26/19 at 6:00 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 55.

4. The facility staff failed to complete an assessment for Resident # 48's use of side rails prior to installation/use.

Resident #48 was admitted to the facility on 5/31/19 with diagnoses that included but were not limited to: high blood pressure, diabetes, atrial fibrillation [a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria. (1)], injuries obtained in a motor-vehicle accident, and a broken fibula.

The most recent MDS (minimum data set) assessment, a Medicare 14 day assessment, with an assessment reference date of 6/14/19, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) scoring, indicating he was capable of making daily cognitive decisions. The resident was coded in Section G - Functional Status as requiring extensive assistance of two staff members for moving in the bed.

The clinical record failed to evidence an assessment for the use of bed rails for Resident

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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
F 700	Continued From page 93	F 700		

Continued From page 93

#54.

The comprehensive care plan dated, 6/12/19, failed to evidence documentation for the use of side rails.

The "Kardex" used by the CNA (certified nursing assistants), dated 5/31/19, documented in part, "Side rails 1/2 up bilateral side rails to promote independence in bed mobility."

Resident #48 was observed on 6/25/19 at 4:25 p.m. in bed with both side rails up. He was again observed on 6/26/19 at 8:06 a.m., in bed with both side rails up.

On 6/26/19, an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails ASM # 2 stated that they did not have assessments for the use of bed rails.

Administrative staff member (ASM) #1, the administrator, was made aware of the above concern on 6/26/19 at 6:00 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 55.

5. The facility staff failed to complete an assessment for Resident #42's use of side rails prior to installation/use.

Resident #42 was admitted to the facility on 1/8/02 with diagnoses that included but were not

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
F 700	Continued From page 94	F 700		

limited to: dementia, amputation of one leg above the knee, and high blood pressure.

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 6/3/19, 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 being dependent upon one or more staff members for moving in the bed.

The clinical record failed to evidence an assessment for the use of bed rails for Resident #42.

The comprehensive care plan dated, 12/5/18, documented in part, "Problem: (Resident #42 has self-care deficit, requires maximum assist with care, dementia and R (right) AKA (above knee amputation)." The "Approaches" documented in part, "1/2 side rails for bed mobility and defining parameters."

The resident was observed in bed on 0/26/19 at 8:15 a.m., in bed with both side rails up.

On 6/26/19, an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails ASM # 2 stated that they did not have assessments for the use of bed rails.

Administrative staff member (ASM) #1, the administrator, was made aware of the above concern on 6/26/19 at 6:00 p.m.

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
F 700	Continued From page 95 No further information was provided prior to exit. 6. The facility staff failed to complete an assessment for Resident # 23's use of side rails prior to installtation/use. Resident #23 was admitted to the facility on 6/30/18 with diagnoses that included but were not limited to: stroke with hemiplegia on one side, depression and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/4/19, coded the resident has having both short and long-term memory difficulties and being severely impaired to make daily cognitive decisions. In Section G - Functional Status, the resident was coded as being dependent upon one or more staff members for moving in the bed. The comprehensive care plan dated, 7/12/18, documented in part, "Problem: (Resident #23 requires assistance with her ADLs due to right side hemiplegia, contractures of right hand an bilateral LEs (lower extremities) and cognitive deficits from a CVA (stroke)." The "Approaches" documented in part, "1/2 side rails up bilaterally to promote independent bed mobility and to define the parameters of the bed." On 6/26/19, an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails ASM # 2 stated that they did not have assessments for the use of bed rails. Administrative staff member (ASM) #1, the	F 700		

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
F 700	Continued From page 96 administrator, was made aware of the above concern on 6/26/19 at 6:00 p.m. No further information was provided prior to exit. 7. The facility staff failed to assess Resident #17 for the use of bed rails prior to installation/use. Resident #17 was admitted to the facility on 05/30/2007. Her diagnoses included hemiplegia (weakness of one side of the body) of the right dominant side, hypertension (high blood pressure), and heart failure (1). Resident #17's most recent Minimum Data Set (MDS) assessment was a quarterly assessment with an Assessment Reference Date (ARD) of 04/30/2019. The Brief Interview for Mental Status (BIMS) was not performed, as Resident #17 was coded as rarely or never understood. Resident #17 was coded as totally dependent on 2 or more people for bed mobility. During initial tour of the facility in the afternoon of 06/25/2019, Resident #17 was observed in bed with bed rails in place at the head of the bed bilaterally. The clinical record and the EHR (electronic health record) for Resident #17 failed to evidence an assessment for the use of bed rails. The comprehensive care plan for Resident #17 with a revision on 05/01/2019 documented, "Approaches: ½ (half) side rails up bilaterally to promote independent mobility and to define the parameters of the bed. Onset Date: 02/06/2019. On 06/26/19, an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being	F 700		

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
F 700	Continued From page 97 assessed for the use of bed rails, ASM # 2 stated that they did not have assessments for the use of bed rails. On 06/27/19 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were informed of the findings. No further information was provided prior to exit. 8. The facility staff failed to assess Resident #35 for the use of bed rails prior to installation/use. Resident #35 was admitted to the facility on 11/02/1025. Her diagnoses included hypertension, arthritis, and contracture of the leg. Resident #35's most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD of 05/22/2019. The BIMS was not conducted, as Resident #35 was coded as rarely or never understood. Resident #35 was coded as being totally dependent on one person for bed mobility. During initial tour of the facility in the afternoon of 06/25/2019, Resident #35 was observed in bed with bed rails in place at the head of the bed bilaterally. The clinical record and the EHR (electronic health record) for Resident #35 failed to evidence an assessment for the use of bed rails. The comprehensive care plan for Resident #35 with a revision on 05/29/2019 documented, "Approaches: ½ (half) side rails up bilaterally to	F 700		

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
F 700	Continued From page 98	F 700		

promote independent mobility and to define the parameters of the bed. Onset Date: 12/04/2018.

On 06/26/19 an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails, ASM # 2 stated that they did not have assessments for the use of bed rails.

On 06/27/19 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were informed of the findings.

No further information was provided prior to exit.

9. The facility staff failed to assess Resident #26 for the use of bed rails prior to installation/use.

Resident #26 was admitted to the facility on 01/23/2014. Her diagnoses included lymphedema (2) and contracture of the knee. The most recent MDS (minimum data set) assessment was a quarterly assessment with an assessment reference date of 05/07/2019. Resident #26 was coded as moderately impaired for cognitive skills for daily decision making. Resident #26 was coded as requiring extensive assist of one person for be mobility.

During initial tour of the facility in the afternoon of 06/25/2019, Resident #26 was observed in bed with bed rails in place at the head of the bed bilaterally.

The clinical record and the EHR (electronic health record) for Resident #26 failed to evidence an

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
F 700	Continued From page 99	F 700		

assessment for the use of bed rails.

The comprehensive care plan for Resident #26 with a revision on 05/28/2019 documented, "Approaches: ½ (half) side rails up bilaterally to promote independent mobility and to define the parameters of the bed. Onset Date: 08/17/2018.

On 06/26/19, an interview was conducted with ASM (administrative staff member) # 2, director of nursing. When asked about residents' being assessed for the use of bed rails ASM # 2 stated that they did not have assessments for the use of bed rails.

On 06/27/19 at approximately 5:00 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, director of nursing, were informed of the findings.

No further information was provided prior to exit.

1. Heart failure is a condition in which the heart can't pump enough blood to meet the body's needs. Heart failure does not mean that your heart has stopped or is about to stop working. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. - https://medlineplus.gov/heartfailure.html

2. Lymphedema is the name of a type of swelling. It happens when lymph builds up in your body's soft tissues. Lymph is a fluid that contains white blood cells that defend against germs. It can build up when the lymph system is damaged or blocked. It usually happens in the arms or legs. - https://medlineplus.gov/lymphedema.html

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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 842	Continued From page 100	F 842		
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 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,	F 842	**F842** **Corrective Action(s):** Resident #10 attending physicians has been notified that the facility failed to notify the physician of resident #10's seizure activity. A facility Incident & 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% review of all resident Medical Records will be conducted by the DON, ADON, and or designee to identify residents at risk. All negative findings will be clarified and/or correct as applicable at time of discovery. A facility Incident & Accident form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All licensed nursing staff, Social Services director, Activity Director and dietary manager will be inserviced by the Regional Nurse Consultant or DON 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 Physician Orders, MAR's, TAR's and departmental notes according to the acceptable professional standards and practices.	

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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 842	Continued From page 101 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. This REQUIREMENT is not met as evidenced by: Based on clinical record review and staff interview it was determined that the facility failed to maintain a complete and accurate clinical record for one of 40 residents in the survey sample, resident # 10. The facility staff failed to document in the clinical record notification to the physician of Resident # 10's seizure.	F 842	**Monitoring:** The DON and Medical Records director are responsible for maintaining compliance. The DON, ADON and/or designee will conduct weekly chart audits coinciding with the Care Plan schedule 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: 08/10/2019**	

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F 842	Continued From page 102	F 842		

The findings include:

Resident # 10 was admitted to the facility on 05/17/2010 and a readmission on 05/15/2017 with diagnoses that included but were not limited to cerebral infarction (1), anxiety (2) and dementia (3).

Resident # 10's most recent comprehensive MDS (minimum dada set) an annual assessment with an ARD (assessment reference date) of 04/15/19 coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 (zero) - 15, two being moderately impaired of cognition for daily decision-making. Resident # 10 was coded as requiring extensive assistance of one staff member for activities of daily living and as independent with eating.

The facility's nurse's notes for Resident # 10 dated 05/16/19 documented, "0650 (6:50 a.m.) Resident was in hallway having a seizure lasting 5 (five) min (minutes). Resident placed [sic] and bed. Resident came out of seizure and started talking around 0655 (6:55 a.m.). Vitals 98-62-20-151/74 (Temperature 98- heart rate 62 beats per minute- respiration 20-blood pressure 151 over 74). Pulse ox (oximetry) 97% (percent) Resp (respiration) is even and non labored. Skin is warm and dry to touch. No acute signs of distress noted at this time."

The facility's nurse's notes for Resident # 10 dated 05/16/19 documented, "2:01 p.m. Follow up resident finished/post po (by mouth) ABT (antibiotic) as ordered for UTI (urinary tract infection). No adverse effects viewed. No c/o (complaint of) nausea and no rash viewed. Also,

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F 842	Continued From page 103	F 842		

follow up resident for seizure he had this morning. No further seizure viewed today. V/S (vital signs): 97.7 (temperature), 64 (heart rate), 20 (respiration), 151/73 (151 over 73 blood pressure), O2 sat (oxygen saturation) 97% on room air. Resident's resp are even and unlabored. Resident is alert, calm and cooperative with staff. He accepted po (by mouth) fluid, meals and meds (medications) as offered without difficulty today. Assist (assistance) care/incontinent care provided with adls (activities of daily living). Resident denies any c/o pain or discomfort. Call bell within reach. No s/s (signs/symptoms) of complication viewed."

Further review of the facility's nurse's notes for Resident # 10 failed to evidence documentation that the physician was notified of Resident # 10's seizure on 05/16/19.

On 06/27/19 at 3:13 p.m., an interview was conducted with ASM (administrative staff member) # 2, director of nursing. ASM #2 was asked to describe when the physician should be notified. ASM # 2 stated, "When there is a change in status, skin tear, new laboratory tests, outside consultations ordered. We keep them notified of everything that is going on. We would notify them at least within 24 hours by phone." When asked if the physician should have been notified of resident # 10's seizure on 05/16/19 ASM # 2 stated yes. ASM # 2 reviewed the nurse's notes dated 05/16/19 and stated that she did not see it documented that the physician was notified. ASM # 2 stated, "I'll check the 24-hour report."

On 06/27/19 at 3:35 p.m., ASM # 2 provided this surveyor with the facility's 24-hour report dated

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F 842	Continued From page 104 06/16/19. The 24-hour documented, "(Resident # 10) MD (medical doctor) notified. ABT/UTI, seizure." When asked if the 24-hour report was part of the clinical record, ASM # 2 stated no. When asked if the notification to the physician should have been documented in Resident # 10 clinical record, ASM # 2 stated, "Yes." 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) A stroke. When blood flow to a part of the brain stops. A stroke is sometimes called a "brain attack." If blood flow is cut off for longer than a few seconds, the brain cannot get nutrients and oxygen. Brain cells can die, causing lasting damage. This information was obtained from the website: https://medlineplus.gov/ency/article/000726.htm . (2) Fear. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anxiety.html #summary. (3) 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.	F 842	RECEIVED JUL 23 2019 VDH/OLC	