Our Home, Our Family, Our Life, Too.

Heritage Hall of Dillwyn • 9 Brickyard Drive • Dillwyn, VA 23936 • (P) 434.983.2050

April 13, 2021

Office of Licensure and Certification
Division of Long Term Care Services
ATTN: Wietske G. Weigel-Delano, Long Term Care Supervisor
9960 Mayland Drive – Suite 401
Henrico, VA 23233

Ms. Weigel-Delano,

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

If I can be of further assistance don't hesitate to contact me at (434) 983-2058.

Sincerely;

Angela H. Moore
Administrator

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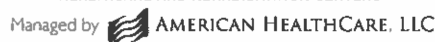
HERITAGE HALL
HEALTHCARE AND REHABILITATION CENTERS



State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	VA0111	A. BUILDING: ______ B. WING ______	03/30/2021

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 000	Initial Comments An unannounced biennial State Licensure Inspection was conducted 3/28/21 through 3/31/21. Corrections are required for compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of thirty-six current residents and two closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12VAC5-371-140. Policies and procedures. Cross reference to F550, F689, F695, F880 12VAC5-371-150. Resident rights. Cross reference to F550 12VAC5-371-180. Infection control. Cross reference to F880 12VAC5-371-210. Nurse staffing. Cross reference to F657 12VAC5-371-220. Nursing services. Cross reference to F550, F677, F688, F695 12VAC5-371-250. Resident assessment and care planning. Cross reference to F656, F657, F677, F688, F695 12VAC5-371-370. Maintenance and housekeeping.	F 001	**F001** **12VAC5-371-140. Policies and procedures. Cross reference to F550, F689, F695, F880** *Cross Reference to POC for F Tag 550* *Cross Reference to POC for F Tag 689* *Cross Reference to POC for F Tag 695* *Cross Reference to POC for F Tag 880* **12VAC5-371-150. Resident rights. Cross reference to F550** *Cross Reference to POC for F Tag 550* **12VAC5-371-180. Infection control. Cross reference to F880** *Cross Reference to POC for F Tag 880* **12VAC5-371-210. Nurse staffing. Cross reference to F657** *Cross Reference to POC for F Tag 657* **12VAC5-371-220. Nursing services. Cross reference to F550, F677, F688, F695** *Cross Reference to POC for F Tag 550* *Cross Reference to POC for F Tag 677* *Cross Reference to POC for F Tag 688* *Cross Reference to POC for F Tag 695*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Georgia H. Moore, Administrator
TITLE
(X6) DATE: 4/13/21

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F 001	Continued From page 1 Cross reference to F689, 584	F 001	**12VAC5-371-250. Resident assessment and care planning. Cross reference to F656, F657, F677, F688, F695** *Cross Reference to POC for F Tag 656* *Cross Reference to POC for F Tag 657* *Cross Reference to POC for F Tag 677* *Cross Reference to POC for F Tag 688* *Cross Reference to POC for F Tag 695* **12VAC5-371-370. Maintenance and housekeeping. Cross reference to F689, 584** *Cross Reference to POC for F Tag 689* *Cross Reference to POC for F Tag 584* **Completion Date: May 10, 2021**	

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	495317	A. BUILDING ______ B. WING ______	03/31/2021

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 03/28/2021 through 03/31/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/28/21 through 3/31/21. No complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 bed Medicare certified facility was 55 at the time of the survey. The survey sample included thirty-six current resident reviews and two closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	**F550** **Corrective Action(s):** Resident #51's attending physician has been notified that the facility staff failed to promote dignity while assisting them with dining. Resident #8's attending physician has been notified that the facility staff failed to promote dignity while assisting them with dining.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angela H. Moore, Administrator
TITLE
(X6) DATE 4/13/2021

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to promote dignity while assisting with dining for two of 38 residents in the survey sample, (Resident #51 and Resident #8). Facility staff were observed standing while feeding Residents #51 and #8. The findings include: 1. Resident 51 was admitted to the facility with diagnoses that include but were not limited to dysphagia (1) and aphasia (2). Resident #51's	F 550	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have the potentially been affected. The Administrator and DON will assess the dining experience and the process for assisting residents with eating. All other negative findings will be addressed at the time of discovery. **Systemic Change(s):** Facility policy and procedures were reviewed. No changes are warranted at this time. The DON and/or Social Services will in-service all staff on the facility policy and procedure regarding resident rights and dignity during mealtimes. The in-service will also cover the procedure assisting residents with eating. **Monitoring:** The DON is responsible for compliance. The DON/designee will complete 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: May 10, 2021**	

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F 550	Continued From page 2 most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/12/2021, coded Resident #51 as being severely impaired for making daily decisions. Section G coded Resident #51 as being totally dependent on one staff member for eating. On 3/29/2021 at approximately 12:30 p.m., an observation was made from the hallway of Resident #51 eating lunch in their room. Resident #51 was observed sitting in a chair in their room with their lunch tray on a bedside table in front of them. CNA (certified nursing assistant) #3 was observed standing beside Resident #51 feeding them lunch. Additional observations at 12:35 p.m. revealed the same findings. The comprehensive care plan dated 8/3/2020 documented in part, "Resident requires a nutritious diet mechanically altered for her enjoyment and weight maintenance...Has dysphagia; at risk for aspiration." The "Approaches" documented in part, "Diet as ordered...Assist with meal as needed. Provide a pleasant dinning [sic] environment and enough time to consume the meal..." On 3/29/2021 at approximately 2:15 p.m., an interview was conducted with CNA #3. CNA #3 stated that Resident #51 required total assistance from staff for eating and required staff to feed them. CNA #3 stated that they were supposed to sit down and have eye to eye contact with residents while feeding them. CNA #3 stated that sitting down, making eye contact and talking to the resident when feeding was a comfort to them. CNA #3 stated that they stood while feeding Resident #51 during lunch because they did not	F 550		

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F 550	Continued From page 3	F 550		

have a chair available to sit down in and they were not supposed to sit on the resident's bed. CNA #3 stated that standing when feeding residents could make the resident feel rushed to eat their meal and was a dignity issue.

On 3/29/21 at approximately 9:21 a.m., ASM (administrative staff member) #1, the administrator provided via email a document titled "Name & title page for nursing standard of practice." The document contained a photocopy of the front cover of the book, "Lippincott Manual of Nursing Practice, 10th Edition."

On 3/30/21 at approximately 9:30 a.m., a request was made to ASM (administrative staff member) #1, for the policy for feeding residents.

The facility policy, "Assistance with Meals" dated "Revised July 2017," documented in part, "...2. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. Not standing over residents while assisting them with meals..."

According to Lippincott Nursing Procedures, 7th edition, pages 320-321, "...A patient who can't self-feed is susceptible to malnutrition. The patient's condition or its associated treatment may also result in pain, nausea, depression, and anorexia. Meeting such a patient's nutritional needs requires determining food preferences; feeding the patient in a friendly, unhurried manner; encouraging self-feeding to promote independence and dignity...Position a chair next to the patient's bed so you can sit comfortably if you need to feed her yourself. Face the patient during feeding, make eye contact, and use a gentle tone of voice..."

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F 550	Continued From page 4	F 550		

On 3/29/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #3, the regional director of clinical services were made aware of the findings.

No further information was provided prior to exit.

References:

(1). Dysphagia is a swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(2). Aphasia- a disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html

2. Resident #8 was admitted to the facility with diagnoses that include but were not limited to dementia (1) and aphasia (2). Resident #8's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 01/15/2021, coded Resident #8 as being moderately impaired for making daily decisions. Section G coded Resident #8 as requiring extensive assistance of one staff member for eating.

On 3/28/2021 at approximately 5:20 p.m., an observation was made from the hallway of Resident #8 eating dinner in their room. Resident

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F 550	Continued From page 5 #8 was observed sitting in their room with their dinner tray on a bedside table in front of them. LPN (licensed practical nurse) #3 was observed standing beside Resident #8 feeding them dinner. Additional observations at 5:30 p.m. revealed the same findings. The comprehensive care plan dated 1/24/2020 documented in part, "[Resident #8] is on a therapeutic diet r/t (related to) cardiac and renal and diabetes dxs (diagnoses). She is over IBW (ideal body weight)..." The "Approaches" documented in part, "...Provide a pleasant dinning [sic] experience and adequate tie [sic] for the meal to be consumed. Assist with meal tray set up as needed and verbal cueing for resident to eat...8/4/20 restorative dinning [sic]." On 3/29/2021 at approximately 3:07 p.m., an interview was conducted with LPN #3. LPN #3 stated that they assisted the CNA's with feeding residents when needed due to staffing. LPN #3 stated that Resident #8 had Alzheimer's disease (3) and wandered away if staff only set up their meal tray and left the resident to eat. LPN #3 stated that Resident #8 did not participate in meals and required total assistance with meals and required staff to feed them now. LPN #3 stated that they encouraged Resident #8 to hold their cup with assistance from the staff. LPN #3 stated that they stood to feed Resident #8 dinner on 3/28/2021 because it was convenient for both them and Resident #8. LPN #3 stated that sitting down and being at eye level with Resident #8 would be more conducive to the task and would promote dignity for Resident #8 during the meal. On 3/29/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the	F 550		

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F 550	Continued From page 6 administrator and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. References: 1. Dementia - 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. Aphasia- a disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.htm l 3. Alzheimer's disease- is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. It is the most common cause of dementia in older adults." This information is taken from the website https://www.nia.nih.gov/health/alzheimers/basics.	F 550		
F 584 SS=D	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 supports for daily living safely. The facility must provide-	F 584	**F584** **Corrective Action(s):** Resident #48's light has been repaired and inspected to ensure it is functioning properly.	

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F 584	Continued From page 7 §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, resident interview, facility staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to provide maintenance services necessary to maintain, a safe	F 584	**Identification of Deficient Practice(s) and Corrective Action(s):** All other resident beds may have potentially been affected. A complete documented review of all lights in resident rooms facility will be conducted by the Maintenance Director and/or Maintenance Assistant to identify those needing repair/replacement. All negative findings will be corrected at the time of discovery. **Systemic Change(s):** The facility's policy & procedure for providing a safe, sanitary, and comfortable environment has been reviewed. No changes are warranted at this time. The Maintenance Director will provide in-services to all staff on facility policy and procedure on the maintenance notification system to use when facility equipment and repairs are noted and needed throughout the facility. **Monitoring:** The Maintenance Director and the administrator are responsible for maintaining compliance. Documented facility rounds will be completed weekly to monitor compliance. The administrator will review the findings of the audits weekly to ensure negative findings are being corrected. Cumulative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice **Completion Date: May 10, 2021**	

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F 584	Continued From page 8	F 584		

comfortable homelike environment for one of 38 residents in the survey sample, (Resident #48). The facility staff failed to repair/ ensure, Resident #48's light was functioning when activated by the wall light switch, despite the resident's repeated requests over five weeks.

The findings include:

Resident #48 was admitted to the facility on 3/31/17, and readmitted on 6/24/17, with diagnoses including history of a stroke and right side paralysis. On the most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 3/9/21, Resident #48 was coded as having no cognitive impairment for making daily decisions, having scored 14 out of 15 on the BIMS (brief interview for mental status). He was coded as requiring the assistance of staff for walking in his room, and as being independent for locomotion around the unit. He was coded as being unsteady with walking, and as having both upper and lower extremity impairment for range of motion. He was coded as using a wheelchair for locomotion.

A review of Resident #48's comprehensive care plan dated 3/17/21 revealed, in part: "[Resident #48] requires assistance with his ADLs (activities of daily living) due to hemiplegia (right side paralysis)....He is at risk for falls due to fall hx (history) and poor mobility...He uses a w/c (wheelchair) for motility...He has use of an electric wheelchair that he has independent mobility in."

On 3/28/21 at 2:13 p.m., Resident #48 was observed riding in a motorized wheelchair out of his room and down the hallway. On 3/28/21 at

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F 584	Continued From page 9 5:03 p.m., Resident #48 was observed sitting in a motorized wheelchair, positioned between his bed and the door. Resident #48's bed was closest to the door. His roommate's bed was closest to the window. During an interview with Resident #48 conducted at this time, Resident #48 stated that the light switch on the wall, just inside the door, did not work for his bed. An attempt was made to turn Resident #48's light on with the switch by the door, and the light over Resident #48's bed did not come on. Resident #48 stated the light had been broken for five weeks, and that he had made repeated requests for someone to fix it. He stated there was a pull cord for the light, but he could not reach it when he was in his wheelchair. Observation revealed a pull cord was attached to the light behind the resident's bed; however, there was not enough room for Resident #48 to maneuver the motorized wheelchair between his bed and his roommate's bed to be able to reach the pull cord. On 3/29/21 at 10:45 a.m., OSM (other staff member) #3, the maintenance director, was asked to provide written evidence of maintenance requests made by residents and addressed by the maintenance staff since 1/1/21. OSM #3 stated that some items are computerized, and he could print those. He stated that most items are requests made by residents as he is walking through the building. OSM #3 stated he "takes care of things," but does not document these kinds of repairs. When asked if he had any requests from Resident #48 for a broken light switch, OSM #3 stated, "I can't remember whether or not he has mentioned it. He might have. I just can't remember. I have not been here that long." He stated he had not repaired Resident #48's light switch in the last five weeks.	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 10 OSM #3 stated, "This building is so old, I don't even know if I could do it. I would have to go up in the wall and ceiling and trace it. I don't know. And he asks me for a lot of things." When asked how quickly residents might reasonably expect a repair to be done, OSM #3 stated, "As soon as I can get to it." On 3/29/21 at 3:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the regional director of clinical services, and LPN (licensed practical nurse) #1, the unit manager, were informed of these concerns. ASM #1 stated OSM #3 is new, and that she would call the retired maintenance director to come in the following day and attempt to take care of Resident #48's light switch. On 3/30/21 at 9:04 a.m., the surveyor went to Resident #48's room. Observation revealed the resident seated in a motorized wheelchair between his bed and the door. At this time Resident #48 stated, "Try the light now." The surveyor flipped the light switch close to the door, and the light came on behind Resident #48's bed. Resident #48 stated, "It was just the lightbulb. They just came in and changed the lightbulb. After all that time, and it was the lightbulb. I just don't understand." On 3/30/21 at 10:21 a.m., during an interview with ASM #1, the administrator, she stated OSM #3 had discovered that there were actually two lightbulbs in Resident #48's light fixture. One bulb was activated by the wall switch; the other bulb was activated by the pull cord. She stated no one at the facility knew about the two bulbs until the discovery that morning.	F 584		

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F 584 — Continued From page 11

A review of the facility policy "Quality of Life - Homelike Environment," revealed, in part: "Residents are provided with a safe, clean, comfortable, and homelike environment ... Staff shall provide person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences."

No further information was provided prior to exit.

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

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

F 656 — Provider's Plan of Correction

F656
Corrective Action(s):
Resident #11's comprehensive care plan has been developed and implemented. It reflects appropriate goals and interventions and approaches to address the resident's specific needs to include their use of a pommel cushion.

Resident #43's comprehensive care plan has been developed and implemented. It reflects appropriate goals and interventions and approaches to address the resident's specific needs to include their use of a wheelchair alarm.

Resident #2's comprehensive care plan has been developed and implemented. It reflects appropriate goals and interventions and approaches to address the resident's specific needs to address and prevent worsening of bilateral hand contractures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 12 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. 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 develop and implement the comprehensive care plan for six of 38 residents in the survey sample, (Residents #11, #43, #2, #21, #5 and #34). The facility staff failed to ensure Resident #11's pommel cushion and Resident #43's wheelchair alarm were implemented to prevent falls per the comprehensive care plan and physician orders. The facility staff failed to develop and implement a care plan for devices to address and prevent the worsening of Resident #2's bilateral hand contractures and failed to develop and implement a comprehensive care plan to address urinary tract infections, the prescribed treatment and care required for Resident #21, #5 and #34. The findings include: 1. The facility staff failed to implement Resident #11's comprehensive care plan for a pommel	F 656	Resident #21's comprehensive care plan has been developed and implemented. It reflects the resident's current needs. Resident #21's attending physician has been notified that the facility staff failed to develop and implement an appropriate comprehensive plan of care for the resident's UTI beginning 2/15/21. Resident #5's comprehensive care plan has been developed and implemented. It reflects the resident's current needs. Resident #5's attending physician has been notified that the facility staff failed to develop and implement an appropriate comprehensive plan of care for the resident's UTI beginning 12/2/20. Resident #34's comprehensive care plan has been developed and implemented. It reflects the resident's current needs. Resident #34's attending physician has been notified that the facility staff failed to develop and implement an appropriate comprehensive plan of care for the resident's UTI beginning 3/23/21. **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 /designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified at risk will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs.	

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F 656 Continued From page 13

cushion.

Resident #11 was admitted to the facility on 3/31/16. Resident #11's diagnoses included but were not limited to heart failure, muscle weakness and anxiety disorder. Resident #11's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/15/21, coded the resident's cognitive skills for daily decision making as moderately impaired.

Review of Resident #11's clinical record revealed a physician's order dated 2/7/20 for a pommel cushion (a cushion that is raised in the front of the wheelchair between the thighs and used to prevent a resident from sliding down and falling out of the wheelchair).

Resident #11's comprehensive care plan with a problem onset date of 4/6/20 documented, "She is at increased risk for falls due to her lack of safety awareness unsteady gait...Approaches: Pommel cushion in w/c (wheelchair)..."

Resident #11's CNA (certified nursing assistant) care plan dated 2/24/21, located in the resident's closet documented, "SAFETY- pommel cushion..."

On 3/29/21 at 8:38 a.m., Resident #11 was observed propelling herself in the wheelchair in the halls. No pommel cushion was observed in the wheelchair.

On 3/29/21 at 9:15 a.m., an interview was conducted with OSM (other staff member) #1 (the rehabilitation director). OSM #1 stated a pommel cushion has an elevated front that raises between a person's legs and keeps the person from sliding

F 656

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 RCC, IDT and the DON will be inserviced by the regional nurse consultant on the development, revision and implementation process of individualized care plans.

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: May 10, 2021

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 ______	03/31/2021

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F 656	Continued From page 14	F 656		

Continued From page 14

out of the chair. OSM #1 stated a pommel cushion is used for residents who have issues with sliding out of the wheelchair or just to keep residents a little more upright in the wheelchair. Resident #11's physician's order for a pommel cushion was reviewed with OSM #1 and then Resident #11 was observed by OSM #1. OSM #1 stated Resident #11 just had a regular cushion and not a pommel cushion.

On 3/29/21 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the purpose of a care plan is so all staff knows how to provide care for residents and knows their needs and limitations. LPN #2 stated residents' care plans are on the unit and residents have information from their care plans in their closets.

On 3/29/21 at 4:40 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The facility policy titled, "Care Plans, Comprehensive Person-Centered" documented, "Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making." The policy did not specifically document information regarding care plan implementation.

No further information was presented prior to exit.

2. The facility staff failed to implement Resident #43's comprehensive care plan for a wheelchair

F 656 Continued From page 15 F 656

alarm.

Resident #43 was admitted to the facility on 1/6/20. Resident #43's diagnoses included but were not limited to difficulty in walking, dementia and urinary tract infection. Resident #43's quarterly MDS (minimum data set), with an ARD (assessment reference date) of 3/4/21, coded the resident's cognitive skills for daily decision making as moderately impaired.

Review of Resident #43's clinical record revealed a physician's order dated 1/7/20 for a pressure alarm to the bed and wheelchair due to the resident's history of falls.

Resident #43's comprehensive care plan with a problem onsite date of 12/3/20, documented, "Resident is at risk for falls due to lack of safety awareness...Approaches: Pressure alarm to bed and w/c (wheelchair)..." Resident #43's CNA (certified nursing assistant) care plan dated 2/24/21, located in the resident's closet documented, "SAFETY- pressure alarm to bed an (sic) w/c..."

On 3/28/21 at 2:25 p.m. and 4:36 p.m., Resident #43 was observed in a wheelchair with no alarm.

On 3/29/21 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated the purpose of a care plan is so all staff knows how to provide care for residents and knows their needs and limitations. LPN #2 stated residents' care plans are on the unit and residents have information from their care plans in their closets.

On 3/29/21 at 2:15 p.m., Resident #43 was

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 ______	03/31/2021

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F 656	Continued From page 16	F 656		

observed in a wheelchair with no alarm. This observation was confirmed by LPN #2.

On 3/29/21 at 4:40 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

No further information was presented prior to exit.

3. The facility staff failed to develop and implement a care plan for devices to address and prevent the worsening of Resident #2's bilateral hand contractures.

Resident #2 was admitted to the facility on 11/24/10, and most recently readmitted on 7/3/17, with diagnoses, including history of a stroke with paralysis, dementia (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/22/20, he was coded as having severe memory impairment for making daily decisions. Resident #2 was coded as fully dependent on the assistance of two staff members for grooming, and as being impaired for range of motion in his arms and legs, both left and right.

On the following dates and times, Resident #2 was observed in his room, with the head of his bed elevated, with both hands contracted, and with no device or material in either hand: 3/28/21 at 2:19 p.m., 2:43 p.m., and 5:05 p.m.; and 3/20/21 at 8:48 a.m. and 12:16 p.m.

A review of Resident #2's comprehensive care plan, dated 9/15/20, revealed, in part: "At risk for

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 ______	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 17 a decline in his ability to perform his own ADLs r/t [related/to] effects from [stroke] immobility paralysis. He has...contractures and cognitive deficits." The care plan contained no reference to any interventions to prevent the worsening of, or improve, Resident #2's hand contractures. On 3/29/21 at 12:23 p.m., RN (registered nurse) #2 was asked to observe Resident #2 and was accompanied to Resident #2's bedside. At this time RN #2 was asked about Resident #2's hand contractures. RN #2 stated that she wasn't certain, but she thought the facility staff, at one time, had used "carrots," which were soft, carrot shaped pillows that fit into a resident's clinched hands to prevent further contraction. RN #2 stated she thought she remembered that the resident had "figured a way to get them out of his hands," so the facility staff had not used them in "a while." RN #2 stated, "You know, there's just not much we can do for the contracture." On 3/29/21 at 1:25 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. She stated a care plan paints a picture of the resident's abilities and needs. She stated the care plan's interventions should include things used to help residents improve and to prevent them from worsening. RN #1 stated information for the comprehensive care plan comes from multiple sources, including the MDS assessments, hospital records, therapy recommendations, physicians' orders, and assessments. RN #1 stated the care plan is necessary to paint a good picture of the resident, and to help the resident as much as is possible. On 3/29/21 at 1:45 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed.	F 656		

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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 ______	03/31/2021

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 18 When asked if the facility has a process for routinely assessing residents for contractures, LPN #1 stated, "I refer them back to therapy." She stated that sometimes, the staff can put a rolled washcloth in residents' hands to prevent the worsening of contractures. When asked if any kind of device to treat contractures should be included on a resident's care plan, LPN #2 stated, "Yes. Absolutely." On 3/29/21 at 2:58 p.m., LPN (licensed practical nurse) #1 was interviewed. When asked about Resident #2's hand contractures, she stated at one time, the staff used the "carrot-looking things" in Resident #2's hands. LPN #1 stated, "But he would somehow work it out of his hands." She stated the facility staff would then try a rolled washcloth in his hands. She stated she did not know if anything was currently in use, or if the therapy staff had made any other types of recommendations. On 3/29/21 at 3:14 p.m., OSM (other staff member) #1, an OT (occupational therapist) and rehabilitation program director, was interviewed. When asked about the process for managing a resident's contractures, she stated the therapists address it if it is brought to their attention. OSM #1 stated, "We screen people every now and again." She stated if the staff notifies the therapists that a resident has hand contractures, the occupational therapists evaluate the resident. She stated the OT team does a lot of "manual therapy." She stated the goal is to get a resting hand splint on the resident. OSM #1 stated if the contractures are too severe for a resting hand splint, the OT team will often recommend the "carrot" device or a rolled washcloth. When asked if the OT team had evaluated Resident #2 and/or	F 656		

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	495317	A. BUILDING ______ B. WING ______	03/31/2021

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F 656	Continued From page 19	F 656		

made any recommendations regarding his hand contractures, she stated she would need to check.

On 3/29/21 at 3:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the regional director of clinical services, and LPN (licensed practical nurse) #1, the unit manager, were informed of these concerns.

On 3/30/21 at 8:36 a.m., OSM #1 provided the surveyor with an OT Evaluation and Plan of Treatment for Resident #2. It was dated 8/30/17, and documented, in part: "Recs (Recommendations):...It is recommended that pt (patient) use a carrot shaped splint in order to increase ROM (range of motion) of fingers/hands in order to improve hand hygiene and decrease tone." She also provided the surveyor with three resident screenings of Resident #2 for OT during 2020. On all three screenings, Resident #2 was determined to have not had a change in his functional status, and not to be a candidate for OT services. OSM #1 stated that at the time of all screenings, the therapy staff was "working under the assumption" that the staff was using the "carrot" device. She stated, according to the 2017 recommendation above, the resident needed some sort of device to prevent the contractures from worsening and to protect his skin on his hands.

A review of the facility policy, "Care Plans, Comprehensive Person-Centered," revealed, 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 ...The

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F 656	Continued From page 20 comprehensive, person-centered care plan will ...describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ....aid in preventing or reducing decline in the resident's functional status and/or functional levels." No further information was provided prior to exit. REFERENCES (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm. 4. The facility staff failed to develop and implement a comprehensive care plan to address Resident #21's urinary tract infection, and treatment. Resident #21 was admitted to the facility on 1/21/21 with diagnoses that included but were not limited to: chronic kidney disease (failure of the kidneys to function properly) (1), cerebrovascular accident (hemorrhage of blockage of vessels of the brain leads to lack of oxygen) (2) and dementia (progressive state of mental decline). (3)	F 656		

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F 656	Continued From page 21	F 656		

The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 1/28/21, coded the resident as scoring a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, transfer, locomotion and eating; and total dependence for hygiene, bathing and dressing. A review of MDS Section H- bowel and bladder coded the resident as frequently incontinent for bowel and for bladder.

Review of Resident #21's physician orders revealed the following orders:
- A physician's order dated 2/11/21, documented in part, "Collect urine culture and sensitivity." - - A physician's order dated 2/15/21, documented in part, "Bactrim (combination antibiotic used to treat UTI) (4) 1 tab [tablet] by mouth twice a day for seven days".
- A physician order dated 2/27/21, documented in part, "Sulfamethoxazole TMP (antibiotic to treat UTI) (5) tablet, give 1 tab by mouth twice a day for seven days".

A review of the nurse's progress notes revealed the following:
- A note dated 2/11/21 at 11:32 AM, documented in part, "Urine noted to be foul smelling. Urine culture obtained and sent to lab [laboratory]".
- A note dated 2/25/21 at 10:12 PM, documented in part, "Resident is on antibiotics for UTI. She is not having any adverse reactions".
- A note dated 3/2/21 at 12:34 PM, documented in part, "Resident is on antibiotics for UTI".

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 ____	03/31/2021

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 22	F 656		

- A note dated 3/25/21 at 2:31 PM, documented in part, "Resident continues on skilled nursing care for UTI".

Review of Resident #21's comprehensive care plan dated 2/7/21 failed to evidence any documented identification of or interventions to address Resident #21's urinary tract infection.

On 3/29/21 at 1:25 PM, an interview was conducted with RN (registered nurse) #1, the MDS coordinator, regarding the purpose of the comprehensive care plan for residents. RN #1 stated, "The purpose of care plan is to paint a picture of the patient and the interventions they need and then the evaluation of the plan. Developing the care plan includes care area assessment from the MDS, diagnosis and orders. I see things I can pull from their medicines, ADL's (activities of daily living), orders, history papers from the hospital anything I need to paint a good picture of them. It is reviewed and revised daily with input from the morning meetings, new orders and reviewed quarterly to see if it is still current, that is when I update it. Annually the dates are revised. I would expect UTI treatment as ordered, signs and symptoms of UTI and hydration to be on the care plan."

An interview was conducted on 3/29/21 at 1:45 PM with LPN (licensed practical nurse) #2, the unit manager regarding the purpose of the comprehensive care plan. LPN #2 stated, "The purpose of the care plan is to identify the care for the resident and their limitations".

On 3/29/20 at 5:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing and ASM #3, the regional

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 ______	03/31/2021

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 23	F 656		

director of clinical services were informed of the above concern.

The facility's "Care Plans, Comprehensive Person-Centered" policy revised 12/2016, documents in part, "A comprehensive, person-centered care plan that includes measurable objectives and time tables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person centered care plan will incorporate identified problem areas."

On 3/30/21 at 7:45 AM, RN #1, the MDS coordinator, provided a revised care plan for Resident #21 and stated, "I revised this yesterday to include UTI. Review of the revised care plan for resident #21 revealed, hand written notes dated 3/29/21, which documented in part, "Positive for UTI, treat with Bactrim."

No further information was provided prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 119.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 111.
3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 154.
4. Lippincott 2019 Pocket Drug Guide for Nurses, Wolters and Kluwer, page 450.
5. Lippincott 2019 Pocket Drug Guide for Nurses, Wolters and Kluwer, page 386.

5. The facility staff failed to develop and implement a comprehensive care plan to address

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 ______	03/31/2021

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 24	F 656		

F 656 Continued From page 24

the treatment and care required for Resident #5's diagnosed urinary tract infection (UTI).

Resident #5 was admitted to the facility on 1/18/19 with diagnoses that included but were not limited to: chronic kidney disease (failure of the kidneys to function properly) (1), dementia (progressive state of mental decline) (2) and diabetes mellitus (inability of insulin to function normally in the body). (3)

The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 12/15/20, coded the resident as scoring a 4 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, dressing, eating, hygiene, and bathing; total dependence in locomotion. A review of MDS Section H- bowel and bladder coded the resident as frequently incontinent for bowel and for bladder. A review of MDS Section I-active diagnosis, coded the resident with UTI-checked. A review of MDS Section N-medications, coded the resident as having antibiotics-checked.
A review of the physician's orders dated 12/2/20, documented in part, "Bactrim (combination antibiotic used to treat UTI) (4) 1 tab [tablet] by mouth twice a day for seven days".

Review of Resident #5's nurse's progress notes revealed the following:
- A note dated 12/2/20 at 3:44 PM, which documented in part, "Doctor called and gave new orders for Bactrim take 1 tab by mouth twice a day for seven days".

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 ______	03/31/2021

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 25 - A note dated 12/5/20 at 2:35 AM, documented in part, "Resident is on follow up for antibiotics for UTI. She is not exhibiting any adverse reactions". - A note dated 12/7/20 at 1:19 PM, documented in part, "Resident is on follow up for antibiotics related to UTI. She is not exhibiting any adverse reactions". A review of Resident #5's comprehensive care plan dated 10/6/20 with revision date of 1/6/21 failed to evidence any documentation addressing urinary tract infections. On 3/29/21 at 1:25 PM, an interview was conducted with RN (registered nurse) #1, the MDS coordinator, regarding the purpose of the comprehensive care plan for residents. RN #1 stated, "The purpose of care plan is to paint a picture of the patient and the interventions they need and then the evaluation of the plan. Developing the care plan includes care area assessment from the MDS, diagnosis and orders. I see things I can pull from their medicines, ADL's (activities of daily living), orders, history papers from the hospital anything I need to paint a good picture of them. It is reviewed and revised daily with input from the morning meetings, new orders and reviewed quarterly to see if it is still current, that is when I update it. Annually the dates are revised. I would expect UTI treatment as ordered, signs and symptoms of UTI and hydration to be on the care plan." An interview was conducted on 3/29/21 at 1:45 PM with LPN (licensed practical nurse) #2, the unit manager regarding the purpose of the comprehensive care plan. LPN #2 stated, "The purpose of the care plan is to identify the care for the resident and their limitations".	F 656		

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APR 16 2021
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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 ______	03/31/2021

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 26	F 656		

On 3/29/20 at 5:00 PM, ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing and ASM #3, the regional director of clinical services were informed of the above concern.

On 3/30/21 at 7:45 AM, RN #1, the MDS coordinator, provided a revised care plan for Resident #5 and stated, "I revised this yesterday to include UTI. Review of the revised care plan revealed hand written notes dated 3/29/21, which documented in part, "Resolved UTI 12/3/20 through 12/9/20 treated with Bactrim and resolved".

No further information was provided prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 119.
2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 154.
3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 160.
4. Lippincott 2019 Pocket Drug Guide for Nurses, Wolters and Kluwer, page 450.

6. The facility staff failed to develop and implement a comprehensive care plan to address the treatment and care required for Resident #34's diagnosed urinary tract infection (UTI).

Resident #34 was admitted to the facility on 2/10/21 with diagnoses that included but were not limited to: cerebrovascular accident (hemorrhage of blockage of vessels of the brain leads to lack of oxygen) (1), dementia (progressive state 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 ______	03/31/2021

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 27	F 656		

mental decline) (2) and diabetes mellitus (inability of insulin to function normally in the body) (3).

The most recent MDS (minimum data set) assessment, a Medicare 5 day assessment, with an ARD (assessment reference date) of 2/20/21, coded the resident as scoring a 6 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the MDS Section G-functional status coded the resident as requiring extensive assistance for bed mobility, dressing, transfers; total dependence for hygiene, and bathing; limited assistance in locomotion and supervision for eating. A review of MDS Section H- bowel and bladder coded the resident as frequently incontinent for bowel and for bladder.

A review of the physician's orders dated 3/23/21, documented in part, "Urine culture and sensitivity. UTI heal (cranberry nutrient for urinary tract health) (4) One ounce by mouth twice a day for chronic UTI's".

A review of the nurse's progress notes for Resident #34 revealed the following:
- A note dated 3/23/21 at 10:32 AM, documented in part, "Doctor gave new orders for urinalysis and urine culture / sensitivity and start UTI heal one ounce by mouth twice a day secondary to chronic UTI's".
- A note dated 3/23/21 at 2:51 PM, documented in part, "Sent urinalysis and urine culture/sensitivity specimen to lab [laboratory]".

A review of Resident #34's comprehensive care plan dated 2/28/21 failed to evidence any documentation addressing a urinary tract infection.

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APR 16 2021
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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 ______	03/31/2021

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 28	F 656		

On 3/29/21 at 1:25 PM, an interview was conducted with RN (registered nurse) #1, the MDS coordinator, regarding the purpose of the comprehensive care plan for residents. RN #1 stated, "The purpose of care plan is to paint a picture of the patient and the interventions they need and then the evaluation of the plan. Developing the care plan includes care area assessment from the MDS, diagnosis and orders. I see things I can pull from their medicines, ADL's (activities of daily living), orders, history papers from the hospital anything I need to paint a good picture of them. It is reviewed and revised daily with input from the morning meetings, new orders and reviewed quarterly to see if it is still current, that is when I update it. Annually the dates are revised. I would expect UTI treatment as ordered, signs and symptoms of UTI and hydration to be on the care plan."

An interview was conducted on 3/29/21 at 1:45 PM with LPN (licensed practical nurse) #2, the unit manager regarding the purpose of the comprehensive care plan. LPN #2 stated, "The purpose of the care plan is to identify the care for the resident and their limitations".
On 3/30/21 at 7:45 AM, RN #1, the MDS coordinator, provided a revised care plan for Resident #34's and stated, "I revised this yesterday to include UTI. Review of the revised care plan revealed hand written notes dated 3/30/21, which documented in part, "UTI heal started 3/23/21 for chronic UTI's".

No further information was provided prior to exit.

References:
1. Barron Dictionary of Medical Terms, 7th

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 ______	03/31/2021

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 29 edition, Rothenberg and Kaplan, page 111. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 154. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 160. 4. DermaRite Product information at Dermarite.com	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced	F 657	**F657** **Corrective Action(s):** Resident #29's comprehensive care plan has been reviewed and revised to reflect current goals, interventions and approaches to address the resident's specific needs. Resident 29's attending physician has been notified that the resident's comprehensive care plan was not revised when he developed an infection in a left heel wound. Resident #14's comprehensive care plan has been reviewed and revised to reflect current goals, interventions and approaches to address the resident's specific needs. Resident 14's attending physician has been notified that the resident's comprehensive care plan was not revised to address the use of oxygen. **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 /designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified at risk will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs.	

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 ______	03/31/2021

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 657	Continued From page 30	F 657		

by:
Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 38 residents in the survey sample, (Residents #29 and #14). The facility failed to revise Resident #29's comprehensive care plan when he developed an infection in a left heel wound and failed to review and revise Resident #14's comprehensive care plan to address the resident's use of oxygen.

The findings include:

1. Resident #29 was admitted to the facility on 7/31/19 with diagnoses including diabetes (1) and dementia (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/4/21, Resident #29 was coded as severely cognitively impaired for making daily decisions. He was coded as having a diabetic ulcer.

On 3/28/21 at 8:45 a.m., Resident #29 was observed sitting up in his wheelchair in his room. A dressing was visible on his left heel.

A review of Resident #29's clinical record revealed the following nurse's note, dated 2/22/21: "New order to start resident on Augmentin (3) 500 mg (milligrams) po (by mouth) TID (three times a day) X 7 days (for seven days) and culture wound on left heel."

A review of Resident #29's MAR (medication administration record) revealed that he received the medication as ordered.

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 ______	03/31/2021

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 657	Continued From page 31 A review of Resident #29's comprehensive care plan, dated 8/10/19, with an updated date of 2/15/21, revealed no information related to the infected heel wound or his receiving an antibiotic. On 3/29/21 at 1:25 p.m., RN (registered nurse) #1, the MDS coordinator, was interviewed. She stated a care plan paints a picture of the resident's abilities and needs. She stated the care plan's interventions should include things used to help residents improve and to prevent them from worsening. RN #1 stated information for the comprehensive care plan comes from multiple sources, including the MDS, hospital records, therapy recommendations, physicians' orders, and assessments. RN #1 stated the care plan is necessary to paint a good picture of the resident, and to help the resident as much as is possible. When asked about how care plans are revised with changes in the resident's condition, she stated the review and revision is a daily thing. RN #1 stated the team has a morning meeting daily, and she picks up on changes during those meetings. When asked if a resident's wound infection and antibiotic use should be included in the care plan, RN #1 stated, "Yes, I just missed it." On 3/29/21 at 3:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the regional director of clinical services, and LPN (licensed practical nurse) #1, the unit manager, were informed of these concerns. A review of the facility policy, "Care Plans, Comprehensive Person-Centered," revealed, in part: "A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical,	F 657		

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APR 16 2021
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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 ______	03/31/2021

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 657	Continued From page 32 psychosocial and functional needs is developed and implemented for each resident ...The comprehensive, person-centered care plan will ...describe services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being ....aid in preventing or reducing decline in the resident's functional status and/or functional levels...Assessments of residents are ongoing and care plans are revised as information about the resident and the residents' conditions change." No further information was provided prior to exit. REFERENCES (1) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html. (2) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (3) "The combination of amoxicillin and clavulanic acid is used to treat certain infections caused by bacteria, including infections of the ears, lungs, sinus, skin, and urinary tract." This information is taken from the website https://medlineplus.gov/druginfo/meds/a685024.html. 2. The facility staff failed to review and revise Resident #14's comprehensive care plan to address the resident's use of oxygen.	F 657		

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APR 16 2021
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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 ______	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 657	Continued From page 33 Resident #14 was admitted to the facility on 10/30/14. Resident #14's diagnoses included but were not limited to chronic atrial fibrillation (1), major depressive disorder and pain. Resident #14's annual MDS (minimum data set) with an ARD (assessment reference date) of 1/22/21, coded the resident's cognitive skills for daily decision making as severely impaired. Review of Resident #14's clinical record revealed a physician's order dated 2/3/21 for oxygen at two liters per minute via nasal cannula. Resident #14's comprehensive care plan with a problem onset date of 1/27/21 failed to reveal documentation regarding the resident's use of oxygen. On 3/28/21 at 2:13 p.m. and 3/29/21 at 8:33 a.m., Resident #14 was observed lying in bed, receiving oxygen via a nasal cannula that was connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set at a rate of three liters as evidenced by the center of the ball in the concentrator flow meter positioned on the three liter line. On 3/29/21 at 1:25 p.m., an interview was conducted with RN (registered nurse) #1, the nurse responsible for reviewing and revising care plans. RN #1 stated reviewing and revising care plans is done on a daily basis, based on information at the morning meeting. RN #1 stated she updates care plans regarding falls, behaviors, diagnoses, medications and new orders. When asked if a resident's care plan should be reviewed and revised to include oxygen use, RN #1 stated, "Yeah. That goes along with COPD (chronic obstructive pulmonary disease)	F 657		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 657	Continued From page 34 (lung disease) as an intervention." On 3/29/21 at 4:40 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 3/30/21 at 7:44 a.m., RN (registered nurse) #1 presented a revised care plan for Resident #14 that documented, "3/29/21- oxygen at 2 l (liters) via NC (nasal cannula)." RN #1 stated the care plan did not previously contain documentation regarding oxygen but she revised the care plan during the previous evening. No further information was presented prior to exit.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; 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 provide ADL (activities of daily living) care to a dependent resident for one of 38 residents in the survey sample, (Resident #2). The facility staff failed to provide nail care and ensure Resident #2's fingernails were trimmed to a safe length. Observation revealed one inch long finger nails on the middle finger of each hand, and half inch long nails on the remaining fingers of both hands. The findings include:	F 677	**F 677** **Corrective Action(s):** Resident #2's attending physician has been notified that the facility staff failed to provide nailcare and ensure Resident #2's fingernails were trimmed to a safe length. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have potentially been affected. The DON/designee will complete a 100% review of all residents for nailcare. Negative findings will corrected at the time of discovery.	

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F 677

Continued From page 35

Resident #2 was admitted to the facility on 11/24/10, and most recently readmitted on 7/3/17, with diagnoses, including history of a stroke with paralysis, dementia (1), and contractures (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 12/22/20, Resident #2 was coded as having severe memory impairment for making daily decisions. He was coded as fully dependent on the assistance of two staff members for grooming, and as being impaired for range of motion in his arms and legs, both left and right.

On the following dates and times, Resident #2 was observed in his room, with the head of his bed elevated, with both hands contracted: 3/28/21 at 2:19 p.m., 2:43 p.m., and 5:05 p.m.; and 3/20/21 at 8:48 a.m. and 12:16 p.m.

A review of Resident #2's comprehensive care plan, dated 9/15/20, revealed, in part: "At risk for a decline in his ability to perform his own ADLs r/t (related/to) effects from [stroke] immobility paralysis. He has...contractures and cognitive deficits."

On 3/29/21 at 12:23 p.m., RN (registered nurse) #2 was accompanied to Resident #2's bedside. RN #2 was asked about Resident #2's hand contractures. RN #2 stated that she wasn't certain, but she thought the facility staff, at one time, had used "carrots," which were soft, carrot shaped pillows that fit into a resident's clinched hands to prevent further contraction. She stated she thought she remembered that the resident had "figured a way to get them out of his hands," so the facility staff had not used them in "a while."

F 677

Systemic Change(s):
The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or designee will provide inservice training to the CNA's to address the importance of providing good grooming and hygiene to include nailcare to all residents. The DON/designee will conduct daily resident care rounds at differing times throughout the day. Residents found in need of nailcare will be corrected at time of discovery and the CNA staff assigned to the resident will receive additional training and/or disciplinary action as appropriate.

Monitoring:
The DON is responsible for maintaining compliance. The DON and/or ADON will perform nailcare audits weekly coinciding with the care plan calendar to insure that their current hygiene needs are addressed. Any/all negative findings will be reported to the DON and RCC for immediate correction. Detail findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice.

Completion Date: May 10, 2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 36 RN #2 stated, "You know, there's just not much we can do for the contracture." When asked to check Resident #2's fingernail length, she checked both hands. RN #2 stated, "I have never seen them this long." She verified that the middle finger nail on each hand was at least one inch long, and the other nails on both hands were between 1/2 inch and one inch. RN #2 stated this was too long for his nails, especially in light of his contractures. She stated with nails this long, the resident was at risk for developing open, raw areas in his hands; she stated these open areas would be prone to infection. RN #2 stated there were no open areas on the resident's skin, and that she would cut his nails "immediately." She stated the CNAs (certified nursing assistants) are usually responsible for nail care, but may not have provided it because of the contractures. RN #2 confirmed that Resident #2 did not have diabetes (3). On 3/29/21 at 1:45 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed. When asked who is responsible for non-diabetic nail care, LPN #2 stated, "The CNAs do the nail care. Some nurses will do it." On 3/29/21 at 3:20 p.m., CNA #2 was interviewed. When asked about fingernail care, she stated she checks residents' nails every day. She stated that she has regularly cut residents' fingernails and toenails if they were not diabetic. CNA #2 stated that Resident #2's fingernails are very hard to cut, and that frequently she asks another staff member to assist her with this. She stated she could not verify or remember the last time she had cut Resident #2's fingernails. On 3/29/21 at 3:30 p.m., ASM (administrative	F 677		

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F 677	Continued From page 37	F 677		

staff member) #1, the administrator, ASM #3, the regional director of clinical services, and LPN (licensed practical nurse) #1, the unit manager, were informed of these concerns.

A review of the facility policy, "Fingernails/Toenails, Care of," revealed, in part: "The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infection ...Nail care includes cleaning and trimming. Proper nail care can aid in the prevention of skin problems around the nail bed ...Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin."

No further information was provided prior to exit.

REFERENCES

(1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm.

(2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.

(3) "Diabetes (mellitus) is a disease in which your blood glucose, or blood sugar, levels are too high." This information is taken from the website https://medlineplus.gov/diabetes.html.

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F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. 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 implement interventions to prevent worsening of a resident's contractures for one of 38 residents in the survey sample, (Resident #2). The facility staff failed to implement use of devices in both of Resident #2's hands to prevent a worsening of his hand contractures. The findings include: Resident #2 was admitted to the facility on 11/24/10, and most recently readmitted on 7/3/17, with diagnoses, including history of a stroke with paralysis, dementia (1), and contractures (2). On the most recent MDS (minimum data set), a	F 688	**F688** **Corrective Action(s):** Resident #2's attending physician has been notified that the facility staff failed to implement interventions to prevent worsening of the resident's contractures. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with orders for devices to prevent worsening of contractures may have been affected. The DON/designee will conduct a 100% review of all residents to identify residents at risk. Negative findings will be corrected at the time of discovery. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The therapy department manager/designee will in-service all nursing staff on the importance of consistently implementing interventions to prevent worsening of contractures. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform weekly audits of all at risk residents to ensure interventions are implemented as ordered. All negative findings will be corrected at time of discovery and appropriate disciplinary action taken for staff members involved. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 10, 2021**	

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	495317	A. BUILDING ______ B. WING ______	03/31/2021

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F 688	Continued From page 39	F 688		

quarterly assessment with an ARD (assessment reference date) of 12/22/20, he was coded as having severe memory impairment for making daily decisions. He was coded as being fully dependent on the assistance of two staff members for grooming, and as being impaired for range of motion in his arms and legs, both left and right.

On the following dates and times, Resident #2 was observed in his room, with the head of his bed elevated, with both hands contracted, and with no device or material in either hand: 3/28/21 at 2:19 p.m., 2:43 p.m., and 5:05 p.m.; and 3/20/21 at 8:48 a.m. and 12:16 p.m.

A review of Resident #2's comprehensive care plan, dated 9/15/20, revealed, in part: "At risk for a decline in his ability to perform his own ADLs r/t [related/to] effects from [stroke] immobility paralysis. He has...contractures and cognitive deficits."

On 3/29/21 at 12:23 p.m., RN (registered nurse) #2 was accompanied to Resident #2's bedside. RN #2 was asked about Resident #2's hand contractures. She stated that she wasn't certain, but she thought the facility staff, at one time, had used "carrots," which were soft, carrot shaped pillows that fit into a resident's clinched hands to prevent further contraction. RN #2 stated she thought she remembered that the resident had "figured a way to get them out of his hands," so the facility staff had not used them in "a while." RN #2 stated, "You know, there's just not much we can do for the contracture."

On 3/29/21 at 1:45 p.m., LPN (licensed practical nurse) #2, the unit manager, was interviewed.

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F 688	Continued From page 40 When asked if the facility has a process for routinely assessing residents for contractures, LPN #2 stated, "I refer them back to therapy." She stated that sometimes, the staff can put a rolled washcloth in residents' hands to prevent the worsening of contractures. On 3/29/21 at 2:58 p.m., LPN #1 was interviewed. When asked about Resident #2's hand contractures, she stated that, at one time, the staff used the "carrot-looking things" in Resident #2's hands. LPN #1 stated, "But he would somehow work it out of his hands." She stated the facility staff would then try a rolled washcloth in his hands. She stated she did not know if anything was currently in use, or if the therapy staff had made any other types of recommendations. On 3/29/21 at 3:14 p.m., OSM (other staff member) #1, an OT (occupational therapist) and rehabilitation program director, was interviewed. When asked about the process for managing a resident's contractures, she stated the therapists address it if it is brought to their attention. OSM #1 stated, "We screen people every now and again." She stated if the staff notifies the therapists that a resident has hand contractures, the occupational therapists evaluate the resident. She stated the OT team does a lot of "manual therapy." OSM #1 stated the goal is to get a resting hand splint on a patient. She stated if the contractures are too severe for a resting hand splint, the OT team will often recommend the "carrot" device or a rolled washcloth. When asked if the OT team had evaluated Resident #2 and/or made any recommendations regarding his hand contractures, she stated she would need to check.	F 688		

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F 688	Continued From page 41 On 3/29/21 at 3:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the regional director of clinical services, and LPN (licensed practical nurse) #1, the unit manager, were informed of these concerns. On 3/30/21 at 8:36 a.m., OSM #1 provided the surveyor with an OT Evaluation and Plan of Treatment for Resident #2. It was dated 8/30/17, and documented, in part: "Recs (Recommendations):...It is recommended that pt (patient) use a carrot shaped splint in order to increase ROM (range of motion) of fingers/hands in order to improve hand hygiene and decrease tone." OSM #1 also provided the surveyor with three resident screenings of Resident #2 for OT during 2020. On all three screenings, Resident #2 was determined to have not had a change in his functional status, and not to be a candidate for OT services. OSM #1 stated that at the time of all screenings, the therapy staff was "working under the assumption" that the staff was using the "carrot" device. She stated, according to the 2017 recommendation above, the resident needed some sort of device to prevent the contractures from worsening and to protect his skin on his hands. A review of the facility policy, "Stroke/TIA (transient ischemic attack) - Clinical Protocol," revealed, in part: "The staff and physician will identify appropriate interventions related to acute stroke, post-stroke care for someone who has recently had a stroke ...Examples of appropriate post-stroke interventions might include rehabilitation therapies, communication support, measures to try to prevent skin breakdown and contractures ..., additional assistance with	F 688		

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F 688	Continued From page 42 activities of daily living (ADLs)." No further information was provided prior to exit. REFERENCES (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (2) "A contracture develops when the normally stretchy (elastic) tissues are replaced by nonstretchy (inelastic) fiber-like tissue. This tissue makes it hard to stretch the area and prevents normal movement." This information is taken from the website https://medlineplus.gov/ency/article/003185.htm.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to implement physician ordered assistive devices to prevent falls for two of 38 residents in the survey sample, (Residents #11	F 689	**F689** **Corrective Action(s):** Resident #11's attending physician has been notified that the facility staff failed to implement use of a pommel cushion as ordered. Resident #43's attending physician has been notified that the facility staff failed to implement use of a wheelchair alarm as ordered.	

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F 689	Continued From page 43 and #43). The facility staff failed to implement a physician ordered pommel cushion for Resident #11 and failed to implement a physician ordered wheel chair alarm for Resident #43. The findings include: 1. Resident #11 was admitted to the facility on 3/31/16. Resident #11's diagnoses included but were not limited to heart failure, muscle weakness and anxiety disorder. Resident #11's quarterly MDS (minimum data set) with an ARD (assessment reference date) of 1/15/21, coded the resident's cognitive skills for daily decision making as moderately impaired. Review of Resident #11's clinical record revealed a physician's order dated 2/7/20 for a pommel cushion (a cushion that is raised in the front of the wheelchair between the thighs and used to prevent a resident from sliding down and falling out of the wheelchair). Resident #11's comprehensive care plan with a problem onset date of 4/6/20 documented, "She is at increased risk for falls due to her lack of safety awareness unsteady gait...Approaches: Pommel cushion in w/c (wheelchair)..." Resident #11's CNA (certified nursing assistant) care plan dated 2/24/21 and located in the resident's closet documented, "SAFETY- pommel cushion..." On 3/29/21 at 8:38 a.m., Resident #11 was observed propelling herself in the wheelchair in the halls. No pommel cushion was observed in the wheelchair.	F 689	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered devices to their wheelchair may have been potentially affected. The DON and/or Unit Manager will conduct a 100% review of all residents with physician ordered devices to their wheelchairs to identify residents at risk. All residents identified at risk will be corrected at time of discovery. **Systemic Change(s):** The facility policy and procedure has been reviewed and no revisions are warranted at this time. The DON and/or regional nurse consultant will inservice all nursing staff regarding proper use of and application of physician ordered wheelchair devices. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform daily inspections of all residents with physician order wheelchair devices to monitor for compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy . **Completion Date: May 10, 2021**	

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F 689	Continued From page 44 On 3/29/21 at 9:15 a.m., an interview was conducted with OSM (other staff member) #1 (the rehabilitation director). OSM #1 stated a pommel cushion has an elevated front that raises between a person's legs and keeps the person from sliding out of the chair. OSM #1 stated a pommel cushion is used for residents who have issues with sliding out of the wheelchair or just to keep residents a little more upright in the wheelchair. Resident #11's physician's order for a pommel cushion was reviewed with OSM #1 and then Resident #11 was observed by OSM #1. OSM #1 stated Resident #11 just had a regular cushion and not a pommel cushion. On 3/29/21 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses and CNAs are aware of resident specific fall interventions such as alarms and pommel cushions because the interventions are documented on physician's orders and on the closet care plans. On 3/29/21 at 4:40 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of clinical services) were made aware of the above concern. On 3/30/21 at approximately 11:00 a.m., a policy regarding falls was requested from ASM #1. A specific policy regarding falls was not provided and the policy titled, "Accidents and Incidents-Investigating and Reporting" did not document information regarding fall prevention interventions. No further information was presented prior to exit.	F 689		

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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 ______	03/31/2021

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 689	Continued From page 45 2. The facility staff failed to implement a physician ordered wheel chair alarm for Resident #43. Resident #43 was admitted to the facility on 1/6/20. Resident #43's diagnoses included but were not limited to difficulty in walking, dementia and urinary tract infection. Resident #43's quarterly MDS (minimum data set), with an ARD (assessment reference date) of 3/4/21, coded the resident's cognitive skills for daily decision making as moderately impaired. Review of Resident #43's clinical record revealed a physician's order dated 1/7/20 for a pressure alarm to the bed and wheelchair due to the resident's history of falls. Resident #43's comprehensive care plan with a problem onsite date of 12/3/20, documented, "Resident is at risk for falls due to lack of safety awareness...Approaches: Pressure alarm to bed and w/c (wheelchair)..." Resident #43's CNA (certified nursing assistant) care plan dated 2/24/21 and located in the resident's closet documented, "SAFETY- pressure alarm to bed an (sic) w/c..." On 3/28/21 at 2:25 p.m. and 4:36 p.m., Resident #43 was observed in a wheelchair with no alarm. On 3/29/21 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated nurses and CNAs are aware of resident specific fall interventions such as alarms because the interventions are documented on physician's orders and on the closet care plans. On 3/29/21 at 2:15 p.m., Resident #43 was	F 689		

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 ____	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 46 observed in a wheelchair with no alarm. This observation was confirmed by LPN #2. On 3/29/21 at 4:40 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of clinical services) were made aware of the above concern. No further information was presented prior to exit.	F 689		
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 that the facility staff failed to provide respiratory care consistent with professional standards of practice, and the comprehensive person-centered care plan, for two of 38 residents in the survey sample, (Resident #14 and Resident #50). The facility staff failed to administer oxygen to Resident #14 at the physician prescribed rate of two LPM (liters per minute) and failed to administer oxygen to Resident #50 at the physician prescribed flow rate of 4 LPM. The findings include:	F 695	**F695** **Corrective Action(s):** Resident #14's attending physician has been notified that the facility staff failed to provide oxygen to the resident at the prescribed flow rate. Resident #50's attending physician has been notified that the facility staff failed to provide oxygen to the resident at the prescribed flow rate. **Identification of Deficient Practices & Corrective Action(s):** All residents receiving oxygen therapy may have potentially been affected. A 100% review of all resident's oxygen orders will be conducted by the DON/designee to identify residents at risk. Residents found to be at risk will be corrected at the time of discovery.	

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	495317	A. BUILDING ______ B. WING ______	03/31/2021

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F 695	Continued From page 47 1. Resident #14 was admitted to the facility on 10/30/14. Resident #14's diagnoses included but were not limited to chronic atrial fibrillation (1), major depressive disorder and pain. Resident #14's annual MDS (minimum data set) with an ARD (assessment reference date) of 1/22/21, coded the resident's cognitive skills for daily decision making as severely impaired. Resident #14's comprehensive care plan with a problem onset date of 1/27/21 failed to reveal documentation regarding oxygen. Review of Resident #14's clinical record revealed a physician's order dated 2/3/21 for oxygen at two liters per minute via nasal cannula. On 3/28/21 at 2:13 p.m. and 3/29/21 at 8:33 a.m., Resident #14 was observed lying in bed and receiving oxygen via a nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator was set at a rate of three liters as evidenced by the center of the ball in the concentrator flow meter positioned on the three liter line. On 3/29/21 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 was asked to describe where the ball in an oxygen concentrator flow meter should be if a resident has a physician's order for two liters of oxygen. LPN #2 stated the middle of the ball should run through the two liter line, right on the two. On 3/29/21 at 2:14 p.m., Resident #14 was lying in bed receiving oxygen via a nasal cannula. LPN #2 observed the resident's oxygen concentrator	F 695	**Systemic Change(s):** The facility policy and procedure for Oxygen administration has been reviewed and no changes were warranted at this time. All licensed nursing staff will be in-serviced on the facility policy and procedure for accurate oxygen administration and monitoring per physician order. In-services will include the delivery of oxygen per physician order. **Monitoring:** The DON is responsible for maintaining compliance. The DON/designee will perform daily audits of all residents using oxygen to monitor for compliance. All negative findings will be corrected at time of discovery and appropriate disciplinary action will be taken as needed. All negative findings will reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: May 10, 2021**	

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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 ______	03/31/2021

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 695		F 695		

Continued From page 48
and stated the concentrator was set at three liters per minute.

On 3/29/21 at 4:40 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #3 (the regional director of clinical services) were made aware of the above concern.

The oxygen concentrator manufacturer's instructions documented, "1. Turn the flowrate knob to the setting prescribed by your physician or therapist. Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min (liter per minute) line prescribed."

The facility policy titled, "Oxygen Administration" documented, "10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered."

No further information was presented prior to exit.

Reference:

(1) "Atrial fibrillation is one of the most common types of arrhythmias, which are irregular heart rhythms. Atrial fibrillation causes your heart to beat much faster than normal. Also, your heart's upper and lower chambers do not work together as they should. When this happens, the lower chambers do not fill completely or pump enough blood to your lungs and body. This can make you feel tired or dizzy, or you may notice heart palpitations or chest pain. Blood also pools in your heart, which increases your risk of forming clots and can leads to strokes or other

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 ______	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 49	F 695		

complications. Atrial fibrillation can also occur without any signs or symptoms. Untreated fibrillation can lead to serious and even life-threatening complications." This information is taken from the website https://www.nhlbi.nih.gov/health-topics/atrial-fibrillation.

2. Resident #50 was admitted to the facility with diagnoses that included but were not limited to acute respiratory failure (1) with hypoxia (2) and obstructive sleep apnea (3).

Resident #50's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 3/11/2021, coded Resident #50 as scoring a 10 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 10- being moderately impaired for making daily decisions. Section O documented Resident #50 receiving oxygen while a resident at the facility.

On 3/28/21 at approximately 2:10 p.m., an interview was conducted with Resident #50. Resident #50 was observed in their room lying in bed wearing a nasal cannula attached to an oxygen concentrator that was running. The oxygen tubing was observed dated 3/24/21 and the center of the ball inside of the flowmeter on the oxygen concentrator was observed set on 3.5 L/min (liters per minute). Resident #50 stated she wore the oxygen all of the time and she was not sure how much oxygen she got. Resident #50 stated that the nurses adjusted the machine to set the oxygen.

Additional observations on 3/28/21 at 4:45 p.m. and 3/29/21 at 9:30 a.m. revealed Resident #50

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APR 16 2021
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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 ______	03/31/2021

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 695	Continued From page 50	F 695		

in bed wearing a nasal cannula, connected to an oxygen concentrator that was running. The oxygen concentrator was set on 3.5 L/min.

The physician's orders dated "March 2021" for Resident #50 documented in part, "1/03/21- Increase O2 (oxygen) to O2 at 4 L/min (liters per minute), via nasal cannula to help maintain O2 sats (saturations) 90% or greater."

The comprehensive care plan for Resident #50 dated 9/16/2020 documented in part, "[Resident #50] has hypoxic respiratory failure caused by her heart failure (4) and pneumonia (5). She is at risk for inadequate blood pumped by the heart to meet the metabolic needs of the body. She is at risk for impaired gas exchange deficit in oxygenation due to heart disease, recent pneumonia and OSA (obstructive sleep apnea). Resident is at risk for unrelieved pain r/t (related to) medical dxs (diagnoses)." Under "Approaches," it documented in part, "...Oxygen as ordered."

On 3/29/21 at 1:45 p.m., an interview was conducted with LPN (licensed practical nurse) #2, unit manager/wound nurse. LPN #2 stated that oxygen was set by centering the ball of the oxygen flowmeter located on the oxygen concentrator in the center of the line beside the prescribed oxygen flow rate.

On 3/29/21 at approximately 2:10 p.m., LPN #2 observed Resident #50's oxygen flow meter. LPN #2 stated that Resident #50's oxygen was set on 3.5 L/min. LPN #2 stated that they were unsure what the prescribed flow rate was and would confirm the physicians order and set the flow meter accordingly.

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 ______	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 51	F 695		

On 3/29/21 at approximately 9:21 a.m., ASM (administrative staff member) #1, the administrator provided via email a document titled "Name & title page for nursing standard of practice." The document contained a photocopy of the front cover of the book, "Lippincott Manual of Nursing Practice, 10th Edition."

On 3/30/21 at approximately 9:30 a.m., a request was made to ASM (administrative staff member) #1, for the policy for oxygen administration and the manufacturer's instructions for use for the oxygen concentrator used by Resident #50.

The facility policy, "Oxygen Administration" dated "Revised October 2010" documented in part," ...Steps in the Procedure...10. Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered..."

The manufacturer's instructions for use provided by the facility titled, "Operator's manual Platinum Series XL, 5, 10 HF II Oxygen Concentrators Standard..." documented in part, "...Note: To properly read the flowmeter, locate the prescribed flowrate line on the flowmeter. Next, turn the flow knob until the ball rises to the line. Now, center the ball on the L/min. line prescribed...."

According to "Lippincott Manual of Nursing Practice," 10th Edition, 2014; p. 239 documented in part, "Administering Oxygen by Nasal Cannula...3. Set the flow rate at the prescribed liters per minute..."

On 3/29/2021 at approximately 4:30 p.m., ASM (administrative staff member) #1, the

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 ______	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 52 administrator and ASM #3, the regional director of clinical services were made aware of the findings. No further information was provided prior to exit. Reference: 1. Acute respiratory failure A condition in which not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. 2. Hypoxia is a condition in which there is a decrease in the oxygen supply to a tissue." This information is taken from the website https://www.cancer.gov/publications/dictionaries/cancer-terms/def/hypoxia. 3. Obstructive sleep apnea (OSA) is a problem in which your breathing pauses during sleep. This occurs because of narrowed or blocked airways. This information was obtained from the website: https://medlineplus.gov/ency/article/000811.htm. 4. Heart failure is a condition in which the heart is no longer able to pump oxygen-rich blood to the rest of the body efficiently. This causes symptoms to occur throughout the body. This information was obtained from the website: https://medlineplus.gov/ency/article/000158.htm. 5. Pneumonia is an infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia. You can also get pneumonia by inhaling a liquid or chemical. This information was obtained from the website: <https://medlineplus.gov/pneumonia.html>	F 695		

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APR 16 2021
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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 _____	03/31/2021

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 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	**F880** **Corrective Action(s):** Resident #30's attending physician has been notified that facility staff failed to implement infection control practices to prevent the spread of infection when a staff member (CNA #4) failed to sanitize her hands before placing an ice scoop in an ice cooler and failed wash/sanitize their hands before picking up the ice scoop and serving ice to Resident #30. CNA #4 has received one on one education regarding handwashing and completing an ice pass. **Identification of Deficient Practice(s) and Corrective Action(s):** All residents may have the potential to be affected by improper infection control practices related to handwashing and passing of ice. The infection preventionist will complete a review of all staff for handwashing and a review of all CNA's for passing of ice utilizing the QA tool. Any negative findings will be addressed immediately, and disciplinary action taken as needed. A facility Incident and Accident form will be completed for each negative finding. **Systemic Change(s):** The facility Infection Control policy and medication administration policy and procedure have been reviewed and no changes are warranted at this time. The infection preventionist has inserviced all staff on handwashing and passing of ice.	

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 ______	03/31/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 54 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement infection control practices to prevent the spread of infection for one of 38 residents in the survey sample, (Resident #30). The facility staff failed to sanitize their hands and failed to store the ice scoop in a sanitary manner to prevent the spread of infection. Observation revealed during ice distribution on 3/28/21, the facility staff without sanitizing their hands placed	F 880	**Monitoring:** The infection preventionist is responsible for maintaining compliance. The infection preventionist will complete QA audits no less than 3 times weekly monitor for compliance. Any negative findings will be corrected at the time of discovery and disciplinary action taken as needed. Aggregate findings of the reports will be submitted to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in the facility policy and procedure. **Compliance Date: May 10, 2021**	

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 ______	03/31/2021

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 880	Continued From page 55	F 880		

the ice scoop into the cooler in direct contact with the ice and failed to wash/sanitize their hands before picking up the ice scoop and serving ice to Resident #30.

The findings include:

Resident #30 was admitted to the facility on 1/23/13, and most recently readmitted on 12/25/20, with diagnoses including Alzheimer's disease (1) and a history of COVID-19 in December 2020 (2). On the most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 2/4/21, he was coded as having severe cognitive impairment for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status).

On 3/28/21 at 2:15 p.m., CNA (certified nursing assistant) #4 was observed leaving the room adjacent to Resident #30's. She was pushing a cart which held a cooler with ice. As she was walking down the hall toward Resident #30's room, using her bare hands, she placed the ice scoop into the cooler, in direct contact with the ice. She was not wearing gloves, and she did not sanitize her hands. When she arrived at Resident #30's doorway, still without sanitizing her hands or wearing gloves, CNA #4 picked the ice scoop up from inside the cooler, scooped ice into a cup, and handed the cup to Resident #30, who immediately ate some of the ice.

On 3/28/21 at 3:06 p.m., CNA #4 was interviewed. She stated she did not usually distribute ice to the residents, and was not sure exactly how it should have been done.

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APR 16 2021
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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 ______	03/31/2021

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 56 On 3/29/21 at 3:20 p.m., CNA #2 was interviewed regarding the procedure staff follows for distributing ice to residents. CNA #2 stated the scoop should always be placed in the pocket outside of the cooler when the scoop is not in use. She stated she does not usually wear gloves, except when she is going into a room where a resident is "sick." On 3/29/21 at approximately 9:21 a.m., ASM (administrative staff member) #1, the administrator provided via email a document titled "Name & title page for nursing standard of practice." The document contained a photocopy of the front cover of the book, "Lippincott Manual of Nursing Practice, 10th Edition." On 3/29/21 at 3:30 p.m., ASM (administrative staff member) #1, the administrator, ASM #3, the regional director of clinical services, and LPN (licensed practical nurse) #1, the unit manager, were informed of these concerns. A review of the facility policy, "Serving Drinking Water," revealed, in part: "Unless the resident is on isolation, take the water pitcher to the ice cart outside the room. Fill the pitcher with ice. Do not let the ice scoop touch the water pitcher." According to the Centers for Disease Control and Prevention (CDC), Recommendations for Environmental Infection Control in Health-Care Facilities: "D.IX. Ice Machines and Ice A. Do not handle ice directly by hand, and wash hands before obtaining ice. B. Use a smooth-surface ice scoop to dispense ice. 1. Keep the ice scoop on a chain short enough	F 880		

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 ______	03/31/2021

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HERITAGE HALL DILLWYN	119 BRICKYARD DRIVE DILLWYN, VA 23936

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F 880	Continued From page 57	F 880		

the scoop cannot touch the floor, or keep the scoop on a clean, hard surface when not in use.
2. Do not store the ice scoop in the ice bin."
This information was obtained from the website: https://www.cdc.gov/infectioncontrol/guidelines/environmental/recommendations.html

"Hand hygiene" is a general term used by the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) to refer to hand washing, antiseptic hand rubbing or surgical hand asepsis. The hands are conduits for almost every transfer of potential pathogens from one patient to another, from a contaminated object to patient, or from a staff member to the patient. Because of this, hand hygiene is the single most important procedure in preventing infection. To protect patients from health care-associated infections, hand hygiene must be performed routinely and thoroughly. ....after contact with inanimate objects in the patient environment." Lippincott Nursing Procedures, Seventh Edition, pages 343-344.

No further information was provided prior to exit.

REFERENCES
(1) "Alzheimer's disease is an irreversible, progressive brain disorder that slowly destroys memory and thinking skills and, eventually, the ability to carry out the simplest tasks. It is the most common cause of dementia in older adults." This information is taken from the website https://www.nia.nih.gov/health/alzheimers/basics.

(2) "Coronaviruses are a large family of viruses found in many different species of animals,

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	495317	A. BUILDING _____ B. WING _____	03/31/2021

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F 880	Continued From page 58 including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments	F 880		

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