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
	495135	A. BUILDING ______ B. WING ______	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL BIG STONE GAP	2045 VALLEY VIEW DRIVE BIG STONE GAP, VA 24219

(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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid complaint survey was conducted 1/7/21 through 1/15/21 with on-site observations occurring on 1/7/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Four (4) complaints were investigated during the survey. The census in this 180 certified bed facility was 122 at the time of the survey. The survey sample consisted of 12 resident reviews.	F 000		
F 656 SS=D	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	F 656	**F 656** **Corrective Action(s):** Resident #4's comprehensive care plan has been reviewed and revised to reflect the resident's inappropriate behavior directed toward staff. **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 care plans which do not address behaviors. Residents identified with inaccurate or incomplete behavior care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their behaviors. A Facility Incident & Accident Form will be completed for each incident identified.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	02/15/21

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 656	Continued From page 1 recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interviews and the review of documents, it was determined the facility staff failed to develop and implement a comprehensive person-centered care plan to include the resident's inappropriate behavior directed toward staff for one (1) of 12 sampled residents (Resident #4). The findings include: Resident #4's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 12/1/2020, had the resident assessed as able to make self understood and as able to understand others. Resident #4's Brief Interview for Mental Status (BIMS) summary score was a 13 out of 15. Resident #4 was assessed as not exhibiting physical behaviors or verbal behaviors. Resident #4 was documented as requiring limited assistance with bed mobility, transfers, toilet use,	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: 2/26/21**	

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F 656	Continued From page 2 and personal hygiene. Resident #4's diagnoses included, but were not limited to: heart failure, high blood pressure, seizure, traumatic brain injury, and depression. Resident #4's clinical documentation provided the following information: - A nursing note dated 11/15/2020 at 2:28 p.m. stated: " ... This nurse talked to resident about inappropriate behavior that (the resident) has been displaying by grabbing female staff as they are walking by ..." - A nursing note dated 12/9/2020 at 4:09 a.m.: " ... Resident was overheard being sexually aggressive with staff. Resident was making sexually suggestive remarks to CNA's [sic] ..." - A nursing note dated 12/13/2020 at 5:24 p.m.: "Resident has made multiple remarks to female staff that insinuate sexual situations ..." - A nursing note dated 12/24/2020 at 2:51 p.m.: " ... Client talks inappropriately to staff and uses sexual inuendos [sic]." - A nursing note dated 12/25/2020 at 5:49 p.m.: "Resident ... continues to make sexual inuendos [sic] to staff members ..." - A nursing note date 12/26/2020 at 5:34 a.m.: " ... Resident continues to make inappropriate sexual comments toward the staff ..." Resident #4's care plan included approaches to address a 'problem' detailed as 'cognitive loss ... (Resident #4's name omitted) has an alteration in thought process (related to) cognitive impairment, seizures, (history of) traumatic brain injury'. Resident #4's care plan also included approaches to address a 'problem' detailed as 'psychotropic/behavior/mood ... (Resident #4's name omitted) has a (diagnosis) of depression and (receives psychotropic medications) daily'.	F 656		

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F 656	Continued From page 3 This care plan did not address Resident #4's inappropriate sexual comments and actions towards staff members. Four (4) of the facility's staff members signed this care plan. One (1) individual signed the care plan on 12/2/2020. Two (2) individuals signed the care plan on 12/14/2020. The finial individual signed the care plan on 12/17/2021. The following addition to Resident #4's care plan was dated 1/2/2021: "(Resident) going in other (resident's) rooms - (Resident) counseled to abstain from going into female residents' rooms and placed on (one-on-one) supervision." The following information was found in a facility policy and procedure titled "Care Planning - Resident" (this policy and procedure was not dated): "Each resident has a Resident Care Plan that is current, individualized, consistent with the medical regimen and updated as needed but at least every 90 days for each resident ... Between Interdisciplinary Conferences, each discipline adds activities to the Resident Care Plan when initiated and discontinues activities when completed." During an interview on 1/15/2020 at 8:41 a.m. with the facility's Assistant Administrator and Administrative Staff Member (ASM) #6 (a nurse consultant), ASM #6 reported Resident #4's aforementioned behaviors were not care planned until 1/2/2021. ASM #6 stated the behaviors were not care planned earlier because they had not occurred during the look-back period of the most recent MDS assessment. ASM #6 confirmed that a resident's care plan could be updated at any time. Revising a resident's care plan is not limited to the completion of a MDS assessment.	F 656		

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F 677	Continued From page 4	F 677		
F 677 SS=E	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 interviews and the review of documents, it was determined the facility staff failed to provide activities of daily living related to personal hygiene for residents showering/bathing needs according to the facility's process for three (3) of 12 sampled residents (Resident #8, Resident #11, and Resident #12). The findings include: 1. The facility staff failed to ensure Resident #8's shower/bathing needs were consistently addressed. Resident #8's minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/17/20 had the resident assessed as being able to make self understood and able to understand others. Resident #8 was assessed as having short-term and long-term memory problems. Resident #8 was assessed as requiring assistance with bed mobility, dressing, eating, toilet use, and personal hygiene. Resident #8's diagnoses included, but were not limited to: high blood pressure, dementia, lung disease, and low potassium. Resident #8's bath/shower documentation was reviewed for October 1, 2020 through January 7, 2021.	F 677	**F 677** **Corrective Action(s):** Resident #8's attending physician has been notified that the facility staff failed provide activities of daily living related to personal hygiene for the weeks of 10/4/20-10/10/20, 10/11/20-10/17/20, 11/22/20-11/28/20, 12/20/20-12/26/20 and 12/27/20-1/2/21; and the facility staff failed to provide personal hygiene at least twice weekly for the weeks of 10/18/20-10/24/20, 10/25/20-10/31/20, 12/6/20-12/12/20 and 12/13/20-12/19/20. Resident #11's attending physician has been notified that the facility staff failed provide activities of daily living related to personal hygiene for the weeks of 11/8/20-11/14/20, 12/13/20-12/19/20, and 12/27/20-1/2/21; and the facility staff failed to provide personal hygiene at least twice weekly for the weeks of 10/4/20-10/10/20, 10/25/20-10/31/20, 11/1/20-11/7/20, 11/15/20-11/21/20, 11/22/20-11/28/20, and 12/20/20-12/26/20. Resident #12's attending physician has been notified that the facility staff failed provide activities of daily living related to personal hygiene for the weeks of 11/8/20-11/14/20 and 11/15/20-11/20/20; and the facility staff failed to provide personal hygiene at least twice weekly for the weeks of 10/11/20-10/17/20, 10/18/20-10/24/20, and 10/25/20-10/31/20.	

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F 677	Continued From page 5 - During this time, there were five (5) weeks where Resident #8 had no baths/showers documented. These weeks were: (1) October 4, 2020 through October 10, 2020; (2) October 11, 2020 through October 17, 2020; (3) November 22, 2020 through November 28, 2020; (4) December 20, 2020 through December 26, 2020; and (5) December 27, 2020 through January 2, 2021. - During this time, there were four (4) weeks were Resident #8 only had one (1) bath/shower documented per week. These weeks were: (1) October 18, 2020 through October 24, 2020; (2) October 25, 2020 through October 31, 2020; (3) December 6, 2020 through December 12, 2020, and (4) December 13, 2020 through December 19, 2020. Resident #8 was care planned for a deficit in ADLs (activities of daily living) due to a decrease in mobility and functional status with approaches that included, but were not limited to: assess and meet ADL care needs and assess ability to perform tasks to determine amount of assistance (if assistance is needed). This problem and these approaches were documented on 8/24/2020 and 11/16/2020. The facility's policy/procedure titled "Bath, Shower/Tub" (revised February 2018) and policy/procedure titled "Bath, Bed" (revised February 2018) were reviewed. Both policies/procedures included the following information: "The purposes of this procedure are to promote cleanliness, provide comfort to the resident and to observe the condition of the resident's skin." These policies/procedures did not detail the frequency at which a resident should be provided a bath/shower. During an	F 677	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have potentially been affected. The DON/designee will complete a 100% review of resident shower/bath records for the last 90 days. An incident and accident report will be completed for all negative findings. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. 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 bathing care to all residents. The DON and ADON's will conduct daily resident care rounds at differing times throughout the day to observe the grooming and hygiene status of all residents. Residents found with improper ADL or hygiene care 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.	

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F 677	Continued From page 6 interview on 1/14/21 at 3:30 p.m., the facility's Assistant Administrator stated the facility did not have a written policy that detailed the frequency for residents to receive a shower/bath. During an interview on 1/14/21 at 2:05 p.m., Resident #8's aforementioned shower/bathing documentation was shared with the facility's Assistant Administrator and Administrative Staff Member (ASM) #6 (a nursing consultant). The Assistant Administrator reported the facility's residents should receive, at a minimum, two (2) showers/baths per week; the Assistant Administrator stated staff would honor a resident's bathing wishes. After reviewing Resident #8's clinical documentation, ASM #6 confirmed they found the same aforementioned shower/bath documentation. No additional bath/shower documentation was provided to the surveyor. 2. The facility staff failed to ensure Resident #11's shower/bathing needs were consistently addressed. Resident #11's minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/29/2020 had the resident assessed being able to make self understood and as being able to understand others. Resident #11's Brief Interview of Mental Status (BIMS) was scored as a two (2) out of 15. Resident #11 was assessed as dependent on the assistance of two (2) individuals with bed mobility, transfers, dressing, toilet use, and personal hygiene. Resident #11's diagnoses included, but were not limited to: anemia, heart disease, high blood pressure, diabetes, and lung disease.	F 677	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or ADON will perform ADL/grooming 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: 2/26/21**	

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F 677	Continued From page 7 Resident #11's bath/shower documentation was reviewed for October 1, 2020 through January 7, 2021. - During this time, there were three (3) weeks where Resident #11 had no baths/showers documented. These weeks were: (1) November 8, 2020 through November 14, 2020; (2) December 13, 2020 through December 19, 2020, and (3) December 27, 2020 through January 2, 2021. (On January 1, 2021, Resident #11 was documented as refusing a bath/shower.) - During this time, there were six (6) weeks were Resident #11 only had one (1) bath/shower documented per week. These weeks were: (1) October 4, 2020 through October 10, 2020; (2) October 25, 2020 through October 31, 2020; (3) November 1 through November 7, 2020; (4) November 15, 2020 through November 21, 2020; (5) November 22, 2020 through November 28, 2020; and (6) December 20, 2020 through December 26, 2020. Resident #11 was care planned as requiring total assistance with ADLs (activities of daily living). Care planned approaches to address ADL needs included, but were not limited to: assist with ADLs as needed, showers two times a week with sponge baths on non-shower days, and keep hair neat and clean. The facility's Assistant Administrator and Administrative Staff Member (ASM) #6 (a nursing consultant) were interviewed on 1/14/21 at 2:05 p.m. The Assistant Administrator reported the facility's residents should receive, at a minimum, two (2) showers/baths per week; the Assistant Administrator stated staff would honor a resident's bathing wishes. After reviewing Resident #11's clinical documentation, ASM #6 confirmed they found the same aforementioned	F 677		

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F 677	Continued From page 8	F 677		

shower/bath documentation. No additional bath/shower documentation was provided to the surveyor.

3. The facility staff failed to ensure Resident #12's shower/bathing needs were consistently addressed.

Resident #12's minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/20/2020 had the resident assessed as being in a persistent vegetative state and/or with no discernible consciousness. Resident #12 was assessed as being dependent on two (2) individuals for bed mobility, toilet use, personal hygiene, and bathing. Resident #12's diagnose included, but were not limited to: anemia, high blood pressure, hyperlipidemia, and dementia.

Resident #12's bath/shower documentation was reviewed for October 1, 2020 through November 20, 2020.
- During this time, there were three (3) weeks when Resident #12 had only one (1) bath/shower documented per week. These weeks were: (1) October 11, 2020 through October 17, 2020; (2) October 18, 2020 through October 24, 2020; and (3) October 25, 2020 through October 31, 2020.
- During this time, there were two (2) weeks when Resident #12 had no baths/showers documented per week. These weeks were: (1) November 8, 2020 through November 14, 2020 and (2) November 15, 2020 through November 20, 2020.

Resident #12 was care planned for a deficit in ADLs (activities of daily living) due to a decrease in mobility and functional status. Approaches for this care plan included, but were not limited to: assess and meet ADL care needs and provide

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F 677	Continued From page 9 privacy. This problem and these approaches were documented on 7/31/2020 and 10/24/2020. During an interview on 1/14/2021 at 1:10 p.m., Administrative Staff Member (ASM) #6 reviewed Resident #12's documentation and confirmed the aforementioned bath/shower findings. The facility's Assistant Administrator and ASM #6 (a nursing consultant) were interviewed on 1/14/21 at 2:05 p.m. The Assistant Administrator reported the facility's residents should receive, at a minimum, two (2) showers/baths per week; the Assistant Administrator stated staff would honor a resident's bathing wishes. No additional bath/shower documentation was provided to the surveyor.	F 677		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional	F 812	**F812** **Corrective Action(s):** The facility's medical director has been notified the staff failed to ensure preparation of food by not maintaining the correct use of the facility's dishwasher. **Identification of Deficient Practices & Corrective Action(s):** All residents may have been potentially affected. The Food Service Manager, and/or Registered Dietician will complete a review of a dishwasher temp logs for the past 90 days to determine dates of noncompliance. A facility Incident and Accident form will be completed for each of negative finding identified.	

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F 812	Continued From page 10 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, document review, and during the course of a complaint investigation, it was determined the facility staff failed to ensure preparation of food by not maintainig the correct use of the facility's dishwasher. The findings include: The facility staff failed to consistently complete the "Daily Temperature Check Sheet - Dish Washer" form; the facility staff failed to ensure the dishwasher temperatures reached the desired level when washing dishes. The facility dietary department was observed on 1/7/2021 at 11:10 a.m. Observations of the January 2021 "Daily Temperature Check Sheet - Dish Washer" log posted in the facility dietary department revealed multiple missing entries. On 1/7/2021 at 1:10 p.m., the facility's Dietary Manager reviewed the December 2020 and January 2021 logs and confirmed they were not complete. The "Daily Temperature Check Sheet - Dish Washer" log had an area for the documentation of the wash temperature, rinse temperature, and sanitizer test to be documented three times a day. The December 2020 log only had 17 entries documented and 14 days had no entries documented. As of noon on January 7, 2021, the January 2021 log had only four (4) entries documented and two (2) days had no entries documented. Dietary Staff Member (DSM) #1 was interviewed about the completion of the aforementioned log; DMS #1 reported it should be completed at least daily. DSM #4 was	F 812	**Systemic Change(s):** Current facility policy & procedure has been reviewed and no changes are warranted at this time. The dietary manager will inservice dietary staff on the proper operation and monitoring for the dishwasher. The inservice will include all aspects of infection & sanitation control measures. **Monitoring:** The Dietary Manager is responsible for maintaining compliance. The Dietary manager randomly monitor the dishwasher temps no less than 2 times weekly and review dishwasher temperature logs each day he is present. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. The results of these audits will be reported to the Quality Assurance Committee for review, analysis, & recommendations for change in facility policy, procedure, and/or practice. **Completion Date: 2/26/21**	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495135	A. BUILDING ___ B. WING ___	C 01/15/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 11 interviewed about the completion of the aforementioned log; DMS #4 reported it should be completed at least every other day. On 1/7/2021 at 2:10 p.m., the surveyor observed four (4) loads of dishes being washed by DSM #5 using the facility's dishwasher. The first load was in progress therefore dishwasher temperatures were not noted. The surveyor noted the dishwasher temperatures during the second load reached a maximum temperature of 115 degrees Fahrenheit during the wash and rinse cycles. During the third and fourth loads the dishwasher temperatures was noted to reach 120 degrees Fahrenheit during the wash and rinse cycles. DSM #5 reported the temperature should be 120 to 130 degrees. (The gauge that displayed the dishwasher temperature was difficult to read due to the lens being cloudy.) The following information was found in a facility policy titled "Dishwashing" (revised on 1/16/2017): "Dishwashing Log ... Policy: The staff will record and monitor the temperatures and sanitizer of the dish machine wash cycle, rinse cycle and sanitizer PPM three times a day at the beginning of the dish washing process on a log provided by the Dining Services Manager each month ... The wash and rinse tank should be a minimum or 120-140 degrees depending on the model number of the machine." Information obtained from the dishwasher company's website indicated the facility's dishwasher should reach a minimum operating temperature of 120 degrees Fahrenheit for both the wash and the sanitizing rinse. On 1/15/2021 at 8:41 a.m., the findings of the	F 812		

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F 812	Continued From page 12 incomplete "Daily Temperature Check Sheet - Dish Washer" and the observations of the dishwasher not achieving the minimum required temperature was discussed with the facility's Assistant Administrator and Administrative Staff Member (ASM) #6. No additional information related to these issues was provided to the surveyor. This is a complaint deficiency.	F 812		